

2007

MOHealthNet Managed
Care Program

External Quality
Review

Report of Findings

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Contract Number: C301154801, Amendment 007

Review Period: January 1, 2007 to December 31, 2007

Draft Submitted on: October 3, 2008

Final Draft Submitted on: November 26, 2008

Final Copy Submitted on: December 30, 2008

Submitted by: Behavioral Health Concepts, Inc. 



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LIST OF ACRONYMS

BA+	Blue-Advantage Plus of Kansas City
BHO	Behavioral Health Management Organization
CAHPS	Consumer Assessment of Health Plans Survey
CDC	Centers for Disease Control and Prevention
Chi-square	A statistical test that is used to examine the probability of a change or difference in rates is due to chance.
CI	Confidence Interval
CMFHP	Children's Mercy Family Health Partners
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services
CPT	Current Procedural Terminology
CY	Calendar Year
DIFP	Department of Insurance, Financial Institutions and Professional Registration
DHHS	U.S. Department of Health and Human Services
DHSS	Missouri Department of Health and Senior Services
DSS	Missouri Department of Social Services
EPSDT	Early, Periodic Screening, Diagnosis and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FFS	MO HealthNet Fee-for-Service
HARMONY	Harmony Health Plan
HCUSA	HealthCare USA
HCY	MO HealthNet Healthy Children and Youth, the Missouri Medicaid EPSDT program

HEDIS	Healthcare Effectiveness Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act
HIS	Health Information Systems
HMO	Health Maintenance Organization
ICD-9	International Classification of Diseases, Ninth Revision, Clinical Modification, World Health Organization
ICN	Internal Control Number
ISCA	Information Systems Capability Assessment
LPHA	Local Public Health Agency
MBE	Minority-owned Business Enterprise
MC+	The name of the Missouri Medicaid Program for families, children, and pregnant women, prior to July 2007.
MC+ MCOs	Missouri Medicaid Program Managed Care Organizations (prior to July 2007)
MCHP	Managed Care Health Plan
MCO	Managed Care Organization
MCP	Mercy CarePlus
MDIFP	Missouri Department of Insurance, Financial Institutions and Professional Registration
MMIS	Medicaid Management Information System
MO HEALTHNET	The name of the Missouri Medicaid Program for families, children, and pregnant women.
MO HealthNet MCHPs	Missouri Medicaid Program Managed Care Health Plans
MOHSAIC	Missouri Public Health Integrated Information System
NCPDP	National Council for Prescription Drug Program
NCQA	National Committee for Quality Assurance

N.S.	Not significant, indicating that a statistical test does not result in the ability to conclude that a real effect exists.
NSF/CMS 1500	National Standard Format/ Center for Medicare and Medicaid Services Form 1500
PCP	Primary Care Provider
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PRO	Peer Review Organization
QA & I	MO HealthNet Managed Care Quality Assessment and Improvement Advisory Group
QI/UM Coordinator	Quality Improvement/Utilization Management Coordinator
SMA	State Medicaid Agency, the Missouri Department of Social Services, MO HealthNet Division
SPHA	State Public Health Agency, the Missouri Department of Health and Senior Services
UB-92	Universal Billing Form 92

GLOSSARY AND OPERATIONAL DEFINITIONS

Administrative Method	The Administrative Method of calculating HEDIS Performance Measures requires the MCHP to identify the denominator and numerator using transaction data or other administrative databases. The Administrative Method outlines the collection and calculation of a measure using only administrative data, including a description of the denominator (i.e., the entire eligible population), the numerator requirements (i.e., the indicated treatment or procedure) and any exclusion(s) allowed for the measure.
Accuracy (Match) Rate	The ratio of identical or correct information in the medical record and the SMA relative to the number of encounters that took place.
Accuracy of a data field	The extent to which an encounter claim field contains the correct type of information (e.g., numeric, alpha, alpha numeric) in the proper format (e.g., mm/dd/yyyy for date field).
Accuracy of the State encounter claims database	The extent to which encounters are being submitted for 100 percent of the services that are provided. ¹
Commission (or surplus encounter claim)	An encounter that is represented in the SMA encounter claims database but not the medical record; or a duplicate encounter.

¹ Medstat (1999). A Guide for States to Assist in the Collection and Analysis of Medicaid Managed Care Data: Second Edition

Completeness of a data field	The extent to which an encounter claim field contains data (either present or absent).
Confidence interval or level	The range of accuracy of a population estimate obtained from a sample.
Encounter data	"Encounter data are records of health care services that have been provided to patients." ²
Error	An error in coding or recording an encounter claim.
Fault (Error) Rate	The ratio of missing and erroneous records relative to the total number of encounters that took place ³ . The rate at which the SMA encounter claims data does not match the medical record or the MCHP paid encounter claims data (the converse of match rate).
Hybrid Method	Hybrid Method requires the MCHP to identify the numerator through both administrative and medical record data. The MCHP reports a rate based on members in the sample who are found through either administrative or medical record data to have received the service identified in the numerator.
Interrater reliability (IRR)	A method of addressing the internal validity of a study by ensuring that data are collected in a consistent manner across data collectors.

² Medstat (1999).: A Guide for States to Assist in the Collection and Analysis of Medicaid Managed Care Data. Medstat: Santa Barbara. Second Edition

³ Centers for Medicare and Medicaid Services (2002). Validating Encounter Data: A protocol for use in conducting Medicaid External Quality Review activities, Final Protocol, Version 1.0, U.S. Department of Health and Human Services.

Omission (or missing encounter claim)	An encounter that occurred but is not represented in the State encounter claims database.
Paid claim	An encounter claim that has been paid by the MCHP.
Probability sample	A sample in which every element in the sampling frame has a known, non-zero probability of being included in a sample. This produces unbiased estimates of population parameters that are linear functions of the observations from the sample data ⁴ .
Random sample	Selection of sampling units from a sampling frame where each unit has an equal probability of selection.
Reasonableness of a data field	The extent to which an encounter claim field represents a valid value (e.g., an actual procedure code, actual birth date); also referred to as validity of the data.
Reliability	The consistency of findings across time, situations, or raters.
Sampling frame	The population of potential sampling units that meet the criteria for selection (e.g., Medical encounter claim types from January 1, 2004 through March 31, 2004).
Sampling unit	Each unit in the sampling frame (e.g., an encounter).
Simple sample	Selection of sampling units from one sampling frame.

⁴ Levy, P.S., Lemeshow, S. (1999). Sampling of Populations: Methods and Applications, Third Edition. John Wiley and Sons: New York.

Unpaid claim

All unpaid and denied claims from the MCHP; All claims not paid by the MCHP either through capitation or through other payment methodology.

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1.0 EXECUTIVE SUMMARY

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I.1 Introduction

The United States Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS) requires an annual, independent external evaluation of State Medicaid Managed Care programs by an External Quality Review Organization (EQRO). External Quality Review is the analysis and evaluation by an approved EQRO of aggregate information on quality, timeliness, and access to health care services furnished by MO HealthNet Managed Care health plans (MCHPs) and their contractors to recipients of MO HealthNet Managed Care services. The Centers for Medicare and Medicaid Services (42 CFR §433 and §438; Medicaid Program, External Quality Review of Medicaid Managed Care Organizations) rule specifies the requirements for evaluation of Medicaid managed care programs. The present report summarizes the findings of the third year of implementation of the mandatory activities for External Quality Review of the MO HealthNet Managed Care Program in Missouri as conducted by Behavioral Health Concepts, Inc., a PRO-Like Entity certified by CMS to conduct External Quality Review (EQR) in all U.S. states and territories.

The State of Missouri contracts with the following MO HealthNet Managed Care health plans represented in this report:

- Mercy CarePlus (MCP)
- HealthCare USA (HCUSA)
- Harmony Health Plan of Missouri (Harmony)
- Missouri Care (MOCare)
- Children's Mercy Family Health Partners (CMFHP)
- Blue-Advantage Plus of Kansas City (BA+)

The EQR technical report analyzes and aggregates data from three mandatory EQR activities and one optional activity as described below:

1) Validating Performance Improvement Projects⁵

Each MO HealthNet Managed Care health plan (MCHP) conducted performance improvement projects (PIPs) during the 12 months preceding the audit; two of these PIPs were validated through a combination of self-selection and EQRO review. The final selection of PIPs to be audited was determined by the State Medicaid Agency (SMA; Missouri Department of Social Services, MO HealthNet Division (MHD)).

2) Validating Performance Measures⁶

The three performance measures validated were HEDIS 2007 measures of Adolescent Well Care Visits, Annual Dental Visit, and Follow-Up After Hospitalization for Mental Illness.

3) Validating Encounter Data⁷ (optional activity)

Validation of Encounter Data examined the completeness, accuracy, and reliability of specific fields in the SMA database; and the extent to which paid claims in the SMA were represented in the medical records of MC+ Managed Care Members; and

4) MO HealthNet Managed Care health plan Compliance with Managed Care Regulations.⁸

The EQRO conducted all protocol activities, with the exception of the MCHP Compliance with Managed Care Regulations Protocol. The SMA conducted these activities and requested the EQRO to review them (Compliance Review Analysis).

⁵ Department of Health and Human Services. Centers for Medicare and Medicaid Services (2002). Validating Performance Improvement Projects: A protocol for use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0, May 1, 2002. Washington, D.C.: Author.

⁶ Department of Health and Human Services. Centers for Medicare and Medicaid Services (2002). Validating Performance Measures: A protocol for use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0, May 1, 2002. Washington, D.C.: Author.

⁷ Department of Health and Human Services. Centers for Medicare and Medicaid Services (2002). Validating Encounter Data: A protocol for use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0, May 1, 2002. Washington, D.C.: Author.

⁸ Department of Health and Human Services. Centers for Medicare and Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR §400, 430, et al., Final Protocol, Version 1.0, February 11, 2003. Washington, D.C.: Author.

1.2 Preparation for the 2007 External Quality Review

PREPARATION WITH THE STATE MEDICAID AGENCY

Effective July 1, 2006 the State of Missouri contract for the External Quality Review of the MO HealthNet Managed Care Program (State of Missouri Contract No: C306122001, Amendment No.: 003) was revised to comply with federal requirements for states to contract with an external, independent entity to implement the mandatory protocols for External Quality Review. The first monthly meeting for planning the scope of work, technical methods and objectives, and analyses was held by the SMA in October 2007. Meetings were held with the SMA and the EQRO in December 2007, January 2008, March 2008, April 2008, June 20, 2008 and August 2008. Additional meetings and teleconference calls were conducted as needed between SMA and EQRO personnel.

At the first meeting in October 2007, the previous years' report was discussed and the plan for the 2007 audit was discussed. During the month of October, the EQRO clarified the SMA's objectives for each of the protocols, developed data requests, prepared detailed proposals for the implementation and analysis of data for each protocol, and prepared materials for SMA review. Written proposals for each protocol were submitted in November 2007 by the EQRO for review, discussion, revision, and approval. By December 2007, the EQRO had negotiated with the SMA the data request for State encounter data to be validated.

PREPARATION OF MO HEALTHNET MANAGED CARE HEALTH PLANS

During October 2007, preparation of MO HealthNet Managed Care health plans for the implementation of the 2007 EQR was conducted by the EQRO Project Director and personnel. To begin, the EQRO Project Director presented a timeline for project implementation and answered MCHP questions at the October 2007 MO HealthNet Managed Care QA&I Advisory Group meeting and MO HealthNet Managed Care All-Plan Meetings. The EQRO Project Director and personnel then conducted

orientation to the protocols and the EQR processes with each MO HealthNet Managed Care health plans.

The EQRO Assistant Project Director arranged the dates of the teleconference calls with health plan QI/UM Coordinators or Plan Administrators. A detailed presentation, tentative list of data requests, and the proposals approved by the SMA were sent to health plans prior to the teleconference orientation sessions. MO HealthNet Managed Care health plans were requested to have all personnel involved in fulfilling the requests or in implementing activities related to the protocols (e.g., performance improvement projects to be validated, performance measures to be validated, encounter data requested) present at the teleconference calls. [The orientation presentation is contained in Appendix 1.] An SMA representative attended all conference calls and received minutes of the meetings taken by the EQRO upon completion of all the calls. Conference calls with EQRO and health plan personnel occurred between December 4, 2007 and December 10, 2007. To avoid confusion and the inundation of multiple requests at once, the requests for information from MO HealthNet Managed Care health plans were implemented in a staged approach from January 2007 through April 2008. All communications (letters, general and specific instructions) were submitted for review, revision, and approval by the SMA prior to sending them to the health plans.

DEVELOPMENT OF WORKSHEETS, TOOLS, AND RATING CRITERIA

The EQRO Project Director, Research Associate, Assistant Project Director, and a healthcare provider were responsible for modifying the worksheets and tools used by the EQRO during the 2006 audit. The EQRO Assistant Project Director revised the worksheet (Attachment B) of the Validating Performance Improvement Project Protocol to add detail for several items that were specific to the MO HealthNet Managed Care Program.

For the Validating Encounter Data Protocol, the EQRO Project Director revised both the data analytic plan in collaboration with the SMA as well as methods and

procedures based on the content, quality and format of data provided by the SMA and health plans. The SMA selected the fields to validate for completeness, accuracy, and reliability of paid claims submitted by MO HealthNet Managed Care health plans. The EQRO developed definitions of all field parameters for review, revision, and approval by the SMA. Encounter data critical field parameters were approved by the SMA at the December 2007 meeting between the SMA and the EQRO.

The Validating Performance Measures Protocol worksheets were revised and updated by the EQRO Project Director and Research Associate to reflect the Performance Measures selected for review for HEDIS 2007. The worksheets had been developed by Behavioral Health Concepts, Inc. staff during the previous year's audit.

The SMA continued to conduct the activities of the MO HealthNet Managed Care Compliance with Managed Care Regulations Protocol through the state contract compliance monitoring process and the work of the EQRO involved the review and evaluation of this information (see Medicaid Program; External Quality Review of Medicaid Managed Care Organizations of 2003, CFR §438.58). The state contract for EQRO requires the review of SMA's activities with regard to the Protocol, however, additional policies and documents were requested prior to and during the on-site visits with health plans when information was incomplete or unclear. To facilitate the review of compliance with federal regulations, the EQRO Assistant Project Director revised a previously developed cross-walk between the SMA contract requirements for Medicaid managed care and the federal Medicaid Managed Care Regulations.

The MO HealthNet Managed Care Program consultant, who has participated in the EQRO for the past six years, reviewed and refined the tool. Feedback on inconsistencies between the MO HealthNet Managed Care contract and federal requirements was provided immediately to the SMA. The EQRO utilized the rating system developed during the 2004 audit to provide ratings for each health plans'

compliance. The SMA provided state compliance review information to the EQRO for all health plans from February 2008 through June 2008. The EQRO staff and the consultant reviewed all available materials and met with SMA staff to clarify SMA comments and compliance ratings; and identify issues for follow-up at site visits. Updates on MO HealthNet Managed Care health plan compliance were provided through early July 2008 to ensure that the EQRO had up-to-date information prior to the beginning of the on-site reviews. Recommended ratings were provided to SMA which were approved for utilization in this report.

The following sections summarize the aggregate findings and conclusions for each of the mandatory protocols. The full report is organized according to each protocol and contains detailed descriptions of the technical methods, objectives, findings, and conclusions (strengths, areas for improvement, and recommendations). In addition, it provides health plan to health plan comparisons and individual MO HealthNet Managed Care health plan summaries for each protocol.

1.3 Validation of Performance Improvement Projects

For the Validating Performance Improvement Projects (PIP) Protocol, the EQRO validated two PIPs for each MO HealthNet Managed Care health plan that were underway during 2007. A total of 12 PIPs were validated. Eligible PIPs for validation were identified by the health plans, SMA, and the EQRO. The final selection of the PIPs for the 2007 validation process was made by the SMA in December 2007. PIPs are to be aimed at studying the effectiveness of clinical or non-clinical interventions, and should improve processes highly associated with healthcare outcomes, and/or healthcare outcomes themselves. They are to be carried out over multiple re-measurement periods to measure: 1) improvement; 2) the need for continued improvement; or 3) stability in improvement as a result of an intervention. Under the State contract for MO HealthNet Managed Care, health plans are required to have two active PIPs, one of which is clinical in nature and one non-clinical. Specific feedback and technical assistance was provided to each health plan by the EQRO during the site visits for improving study methods, data collection, and analysis.

ACCESS TO CARE

Access to care was an important theme addressed throughout all the PIP submissions reviewed. Five of the PIPs utilized enhanced case management procedures to ensure that members had access to care, were reminded of appointments, and that case managers were available to ensure that barriers to services were decreased. Two health plans focused on education and support to obtain appropriate services and medications for the treatment of asthma and access to lead screening (Missouri Care and Harmony Health Plan). All the projects reviewed used the format of the PIP to improve access to care for members. Three of the projects clearly focused on ensuring the members had adequate and timely access to services after being hospitalized for mental health related issues (HealthCare USA, Missouri Care, BA+). The on-site discussions with health plan staff indicate the realization that improving access to care is an ongoing aspect of all

projects that are developed. One health plan (Mercy CarePlus), developed an ongoing PIP into a project that provides case management services to all pregnant members. As outcome data are finalized, and as an example of both improved access and quality of care, this project should become a best practice to be shared throughout the health plans.

QUALITY OF CARE

Topic identification was an area that provided evidence of the attention placed on providing quality services to members. Intervention development for PIPs also focused on the issue of quality services. All PIPs reviewed focused on topics that needed improvement, either in the internal processes used to operate the health plan, or in the direct provision of services delivered. The corresponding interventions that address barriers to quality care and health outcomes were clearly evident in the narratives submitted. There was further evidence of a commitment to quality of care during on-site discussion at each health plan, including the desire to supply supplemental and updated information to ensure that project efforts and outcomes were clearly reported. These interventions addressed key aspects of enrollee care and services, such as medication and treatment management; risk identification and stratification for various levels of care; monitoring provider access and quality services; and preventive care. These efforts exemplified an attention to quality healthcare services.

TIMELINESS OF CARE

Timeliness of care was the major focus of a number of the PIPs reviewed. Three projects identified the need for timely aftercare for members who required inpatient hospitalization for mental illness (HealthCare USA, Missouri Care, and BA+). The remaining projects focused on subjects such as timely processing and resolution of grievances and appeals (HealthCare USA, and BA+), appropriate medications and treatment for asthma (Missouri Care), improved access to non emergent transportation services (Children's Mercy Family Health Partners), improved access to well-child visits in the first 15 months of life (Children's Mercy Family Health Partners). All addressed the need for timely access to preventive and primary health care services. The health plans all related their awareness of the need to provide not only quality, but timely services to members. Projects reflected this awareness in that they addressed internal processes and direct service improvement.

RECOMMENDATIONS

1. It is recommended that health plans continue to refine their skills in the development and implementation of the Performance Improvement Projects. Improved training, assistance and expertise for the design, statistical analysis, and interpretation of PIP findings are available. One health plan (Children's Mercy Family Health Partners) continues to utilize the services of a statistician from a local university to ensure valid and reliable findings.
2. In the design of PIPs, the health plans need to use generally accepted practices for program evaluation to conduct PIPs. In addition to training on the development of PIPs and on-site technical assistance, references to the CMS protocol, "Conducting Performance Improvement Projects" were recommended by the EQRO at each health plan as a guideline to frame the development, reporting and analysis of the PIP.
3. PIPs should be conducted on an ongoing basis, with at least quarterly measurement of some indices to provide data about the need for changes in implementation, data collection, or interventions.
4. PIPs that are not yet complete should include narrative reflecting next steps and a plan for how the PIP will be maintained and enhanced for future years.
5. It appears that in most instances the health plans conduct PIPs on an ongoing basis as part of their quality improvement program. Continuing to utilize these PIPs as tools to improve the organizations' ability to serve members is beneficial.

1.4 Validation of Performance Measures

The Validating Performance Measures Protocol requires the validation or calculation of three performance measures at each MO HealthNet Managed Care health plan by the EQRO. The measures selected for validation by the SMA are required to be submitted by each health plan on an annual basis. The measures were also submitted by the State Public Health Agency (SPHA; Missouri Department of Health and Senior Services; DHSS) for all Managed Care Organizations (MCOs) operating in the State of Missouri. They were: 1) HEDIS 2007 Follow-Up After Hospitalization for Mental Illness; 2) HEDIS 2007 Adolescent Well-Care Visit; and 3) HEDIS 2007 Annual Dental Visit. Detailed specifications for the calculation of these measures were developed by the National Committee for Quality Assurance (NCQA), a national accrediting organization for managed care organizations. The EQRO examined the information systems, detailed algorithms, health plan extract files, medical records, and data submissions provided to the SPHA to conduct the validation activities of this protocol. The data reported to the SPHA was based on MO HealthNet Managed Care health plan performance during 2006.

QUALITY OF CARE

The HEDIS 2007 Follow-Up After Hospitalization for Mental Illness measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care received by health plan members.

One MO HealthNet Managed Care health plan was Fully Compliant with the specifications for calculation of this measure. The four remaining MO HealthNet Managed Care health plans were substantially compliant with the specifications for calculation of this measure. (Harmony is not included in this evaluation as they were not a Missouri provider during the HEDIS 2007 measurement period.)

For the 7-day follow up rate, three MO HealthNet Managed Care health plans (BA+, CMFHP and MO Care) reported rates (58.67%, 48.50% and 42.58%, respectively) that were higher than the National Medicaid Average (39.1%) for this measure and one

health plan (BA+) reported a rate higher than the National Commercial Average (56.7%).

The 7-Day reported rate for all MO HealthNet Managed Care health plans in 2007 (35.52%) was a 4.36% increase over the 7-day rate reported in 2006 (the last year this measure was audited by the EQR).

For the 30-day follow up rate, three MO HealthNet Managed Care health plans (BA+, CMFHP and MO Care) reported rates (76.00%, 88.37% and 63.16%, respectively) that were higher than the National Medicaid Average (57.7%) for this measure and two health plans (BA+ and CMFHP) reported rates higher than the National Commercial Average (75.0%).

The 30-Day reported rate for all MO HealthNet Managed Care health plans in 2007 (60.06%) was a 7.14% increase over the 30-day rate reported in 2006 (the last year this measure was audited by the EQR).

Due to the high rates reported for this measure it can be concluded that MO HealthNet Managed Care health plan members are receiving a higher quality of care in the area of Follow-Up After Hospitalization for Mental Illness than other Medicaid recipients across the country.

ACCESS TO CARE

The HEDIS 2007 Annual Dental Visit measure is categorized as an Access/Availability of Service measure and is designated to measure the access to care received.

For the Annual Dental Visit measure, all five MC HealthNet Managed Care health plans reviewed were substantially compliant with the calculation of this measure.

The rate for All MO HealthNet Managed Care health plans of Annual Dental visits improved by 2.74% from the 2005 rate (the last year this measure was validated by the EQRO) of 29.76% to the 2007 rate of 32.50%. Thereby showing an increased level of dental care received in Missouri during the HEDIS 2007 measurement year.

For the Annual Dental Visit measure, none of the health plans reported a rate higher than the National Medicaid Average (42.5%).

TIMELINESS OF CARE

The HEDIS 2007 Adolescent Well Care Visits is categorized as a Use of Services measure and is designated to measure the timeliness of the care received. To increase the rate for both of these measures, age specific services must be delivered to members on a yearly basis.

For the Adolescent Well Care Visits measure, one health plan was fully compliant with the specifications for calculation of this measure and the remaining four were substantially compliant with the measure's calculation.

For the Adolescent Well Care Visits measure, two health plans (CMFHP and MO Care) reported rates (42.82% and 44.91%, respectively) higher than the National Commercial Average (40.3%) and one health plan (MO Care) reported a rate higher than the National Medicaid Rate (43.6%), as well.

The rate for All MO HealthNet Managed Care health plans improved by 4.68% from the 2004 reported rate of 30.13% for all health plans (the last year this measure was validated by the EQRO) to the 2007 rate for all health plans of 34.81%. Thereby showing an increased level of well care visits delivered to adolescents in Missouri during the HEDIS 2007 measurement year.

RECOMMENDATIONS

1. The SMA should consider requiring the Hybrid Method of calculation for some HEDIS measures. The two health plans who calculated the Adolescent Well Care Visits measure hybridly (CMFHP and MO Care) had the highest validated rates (42.82 % and 44.91%, respectively) and rates above both

- National benchmarks (National Commercial rate 40.3% and National Medicaid rate 43.6%).
2. The SMA should encourage technical assistance regarding the calculation of HEDIS performance measures and medical record review processes for the calculation of performance measures.
 3. MO HealthNet Managed Care health plans with significantly lower rates of eligible members and administrative hits should closely examine the potential reasons for fewer members or services identified. This may be due to member characteristics, but is more likely due to administration procedures and system characteristics such as the proportion of members receiving services from capitated providers. Identifying methods of improving administrative hits will improve the accuracy in calculating the measures.
 4. The SMA should continue to have the EQRO validate the calculation of at least one measure from year to year, for comparison and analysis of trend data.
 5. MO HealthNet Managed Care health plans should run query reports early enough in the HEDIS season so that they may effectuate change in rates where interventions could easily be implemented.

1.5 Encounter Data Validation

Encounter claims data are used by SMAs to conduct rate setting and quality improvement evaluation. Before SMA encounter claims data can be used, it is necessary to establish the extent to which the data for critical fields (e.g., diagnosis and procedure codes, units and dates of service, member and provider identifiers) are complete (each field contains information), accurate (the information contained in each field is of the right size and type), and valid (the information represents actual dates or procedure and diagnosis codes). Several critical fields for each of six claim types (Medical, Dental, Home Health, Inpatient, Outpatient Hospital, and Pharmacy) were identified by the SMA and examined by the EQRO for completeness, accuracy, and validity using an extract file from SMA paid encounter claims. To examine the extent to which the SMA encounter claims database was

complete (the extent to which SMA encounter claims database represents all claims paid by MO HealthNet Managed Care health plans); the level and consistency of services was evaluated by examining the rate of each of six claim types. Additionally, the representativeness (or completeness) of the SMA encounter claims database was examined by comparing data in the SMA encounter claims database to the medical records of members. A random sample of medical records was used to compare the diagnosis codes, procedure codes, drug name dispensed, and drug quantity dispensed in the SMA encounter claims database with documentation in MC+ member medical records. The findings of these comparisons were used to determine the completeness of the SMA encounter claims database in regards to the medical records of members. The completeness of the SMA paid encounter claims was then compared with MO HealthNet Managed Care health plan records of paid and unpaid claims. This proved to be a difficult task, as all of the health plan data submissions did not include unique claim identifiers that could be used to accomplish this comparison, this is not a health plan issue, these unique claim identifiers are not available until a claim is of paid status. All six MO HealthNet Managed Care health plans provided data in the format necessary to make the comparisons. This was the first year that all health plans have done this correctly. The results obtained are detailed in the results of the Aggregate Encounter Data Validation section of this report.

STRENGTHS

1. All Dental and Pharmacy claim type fields examined were 100.00% complete, accurate and valid for all MO HealthNet Managed Care health plans. The SMA encounter claims data critical fields examined for accepted and paid claims of this type are valid for analysis.
2. For all MO HealthNet Managed Care health plans, the first Outpatient Diagnosis Code field was 100.0% complete, accurate and valid.
3. All MO HealthNet Managed Care health plans submitted data in the format requested, and the EQRO was able to perform the analysis of paid and unpaid claims contained in the SMA database.
4. The examination of the level, volume, and consistency of services found significant variability between MO HealthNet Managed Care health plans in the rate of each type of claim (Medical, Dental, Inpatient, Outpatient Hospital, Home Health, and Pharmacy), with no patterns of variation noted by Region or type of MO HealthNet Managed Care health plan.
5. There were no unmatched “paid” encounters within all claim types (Inpatient, Outpatient, and Pharmacy) for all Managed Care health plans.
6. Unpaid claims represent less than .01% of all claims submitted to the SMA.

AREAS FOR IMPROVEMENT

1. For all MO HealthNet Managed Care health plans, all unmatched encounters were due to missing ICN numbers, which are required to match the encounter to that of the SMA.
2. The Procedure Code field in the Outpatient Home Health and Outpatient Hospital claim types included some invalid information. Most of this was due to blank fields or fields containing “00000”.
3. The Inpatient first diagnosis claim field contained incomplete, invalid, and inaccurate fields.
4. The match rates between the SMA database and MO HealthNet Managed Care health plan medical records for claim type procedures were 52.0%, a significant decrease from last year’s match rate of 73.24%. Medical records

that did not have procedure codes that matched the SMA encounter claims extract file were in error primarily due to missing or incorrect information.

5. The match rates between the SMA database and MO HealthNet Managed Care health plan medical records for claim type diagnoses were 47.0%; this is significantly lower than last year's match rate of 70.56%. Medical records that did not have procedure codes that matched the SMA encounter claims extract file were in error primarily due to missing or incorrect information.

RECOMMENDATIONS

1. It is recommended that the SMA institute additional edits for the Medical, Inpatient and Outpatient Hospital claim types to edit claims with blank fields or dummy values (e.g., "000" and "99999999").
2. The SMA should continue to provide timely feedback to MO HealthNet Managed Care health plans regarding the rate of acceptance of each claim type and the types of errors associated with rejected claims.
3. Additional analysis on the rate of consistency of services should examine demographic (e.g., age and gender distribution), epidemiological (diagnostic variables), and service delivery (e.g., number of users per month, rate of procedures or claim types, units of service rates) characteristics to explain variation across health plans or Regions.
4. MO HealthNet Managed Care health plans' medical record reviews should be targeted toward validation of diagnosis and procedure codes and/or descriptors.
5. The SMA should clarify the expectations for MO HealthNet Managed Care health plans in the level of completeness, accuracy, and validity and which data fields are required (e.g., Diagnosis Code fields 2 through 5).
6. The SMA should provide timely feedback to MO HealthNet Managed Care health plans when standards are not met and develop corrective action plans when standards are not met within a reasonable amount of time as established by the SMA.

7. The MO HealthNet Managed Care health plans should all investigate the reasons for the much lower match rates between diagnosis and procedures found by the EQRO during the 2007 report versus the rates found in the 2006 report.

1.6 MO HealthNet MCHP Compliance with Managed Care Regulations

The purpose of the protocol to monitor health plan Compliance with Managed Care Regulations is to provide an independent review of MO HealthNet Managed Care health plan activities and assess the outcomes of timeliness and access to the services provided by the health plan. The protocol requires the utilization of two main sources of information to determine compliance with federal regulations. These sources of information are document review and interviews with health plan personnel. This combination of information was designed to provide the SMA with a better understanding of organizational performance at each MO HealthNet Managed Care health plan.

The policy and practice in the operation of each health plan was evaluated against the seventy (70) regulations related to operating a Medicaid managed care program. The regulations were grouped into three main categories: Enrollee Rights and Protections, Quality Assessment and Improvement, and Grievance Systems. The category of Quality Assessment and Improvement was subdivided into three subcategories: Access Standards, Structure and Operation Standards, and Measurement and Improvement. Initially, the SMA reviewed each MO HealthNet Managed Care health plan's policy to determine compliance with the requirements of the MO HealthNet Managed Care Contract. These determinations and their application to the requirements of the federal regulations were assessed by the EQRO. The EQRO also focused on follow up to the findings reported in the 2005 and 2006 reports by concentrating efforts of technical assistance and assessment on the items that were rated "Partially Met" or "Not Met" in those report years. Additional document review occurred when the health plan policy submission did not meet MO HealthNet Managed Care contract requirements, or where clarification was necessary. An interview tool was developed for Member Services staff, Case Managers, and Plan Administrative Staff in the effort to validate that organizational practice was in concert with approved policies and procedures. The interviews

focused on the Member Services staff and the Case Managers, as these are the individuals at each health plan who have direct contact with MO HealthNet Managed Care members. Administrative interviews were developed on-site and focused on clarification of responses received in the staff interview, particularly when a response was incongruent with approved organizational policies, and explored issues that remained in question following the document review. It is noted that five of the six MO HealthNet Managed Care plans were 100% compliant with not only producing policies and procedures they met the requirements of the federal regulations, but also with practice that meets or exceeds these requirements. The one health plan that was not in full compliance is undergoing their first compliance review. They continue to work with the SMA to bring all written policy into compliance, but also to develop an array and method of service delivery that complies with federal and state requirements.

QUALITY OF CARE

Eight of the 13 regulations for Enrollee Rights and Protections were 100% "Met." Communicating MO HealthNet Managed Care Members' rights to respect, privacy, and treatment options, as well as communicating, orally and in writing, in their own language or with the provision of interpretive services is an area of strength for all health plans. The MO HealthNet Managed Care health plans communicated that meeting these requirements with members and providers, created an atmosphere with the expectation of delivering quality healthcare. The health plans maintained an awareness of and appropriate responses to cultural and language barriers concerning communication in obtaining healthcare. The health plans responded to physical, emotional and cultural barriers experienced by members with diligence and creativity. The health plans were aware of their need to provide quality services to members in a timely and effective manner.

Seven of the 10 regulations for Structure and Operations Standards were 100% "Met." These included provider selection, and network maintenance, subcontractual relationships, and delegation. The health plans had active

mechanisms for oversight of all subcontractors in place. All health plans improved significantly in compliance with this set of regulations and articulated their understanding that maintaining compliance in this area enabled them to provide quality services to their MO HealthNet Managed Care Members.

ACCESS TO CARE

Five of the MO HealthNet Managed Care health plans were fully compliant with the 17 federal regulations concerning Access Standards. These included: provider networks; freedom of choice and access to all services; out-of-network services; timely access to care; care coordination; authorization of services; appropriate notifications; timeliness of decisions regarding care and emergency and post-stabilization services. The six MO HealthNet Managed Care health plans monitored high risk MO HealthNet Managed Care Members and had active case management services in place. Each health plan described measures they used to identify and provide services to MO HealthNet Managed Care Members who have special healthcare needs. Many of these case management programs exceeded the strict requirements in the MO HealthNet Managed Care contract. All six health plans could describe efforts to participate in community events and forums to provide education to members regarding the use of PCPs, special programs available, and how to access their PCP and other specialist service providers that might be required. The health plans were crucially aware of their responsibility to provide access to care and services, and to communicate complete information on this topic to their members.

TIMELINESS OF CARE

Four of the 12 regulations for Measurement and Improvement were 100% “Met.” Five of the six MO HealthNet Managed Care health plans met all of the regulatory requirements. All six health plans adopted, disseminated and applied practice guidelines to ensure sound and timely healthcare services for members. The health plans used their health information systems to examine the appropriate utilization of

care using national standard guidelines for utilization management. The health plans were beginning to utilize the data and demographics in their systems to track and trend information on members to assist in determinations of risk and prevention initiatives. Several health plans began using member and community based quality improvement groups to assist in determining barriers to services and methods to improve service delivery. The Member Services and Case Management departments had integral working relationships with the Provider Services and Relations Departments of the health plans. All front line staff and administrators interviewed exhibited a commitment to relationship building, as well as monitoring providers to ensure that all standards of care were met and that good service, decision-making, and sound healthcare practices occurred on behalf of health plan members. The health plans all provided examples of how these relationships served to ensure that members received timely and effective healthcare. The health plan staff would contact providers directly to make appointments whenever members expressed difficulty in obtaining timely services.

All 18 regulations for Grievance Systems were 100% “Met” for five of the health plans. One health plan (Harmony Health Care of Missouri) continues to work toward completion of adequate and approved policy with the SMA. The five remaining health plans were 100% compliant with the requirements for policy, procedure and practice in the area of Grievance Systems. The health plans provided examples of how timely decision-making allowed members to obtain their healthcare quickly and in the most appropriate setting. The health plans understood that maintaining this system was an essential component to ensuring timely access to healthcare.

MO HealthNet Managed Care health plans remained invested in developing programs and providing services beyond the strict obligations of the contracts. Preventive health and screening initiatives exhibited a commitment to providing the best healthcare in the least invasive manner to their members. Partnerships with local universities and medical schools provided opportunities to obtain cutting-edge and occasionally experimental treatment options, which would not otherwise be

available to members. The health plans observed that these efforts combined to create a system that allowed members timely access to quality healthcare.

RECOMMENDATIONS

1. Continue to distribute the completed compliance tools to the health plans to ensure recognition of the policies and procedures that must be completed and approved to achieve compliance with federal regulations.
2. MO HealthNet Managed Care health plans must continue to recognize the need for timely submission of all required policy and procedures. The majority of the health plans put a tracking or monitoring system into place to ensure timely submission of documentation requiring annual approval. These systems must be maintained to ensure that this process remains a priority for all health plans.
3. MO HealthNet Managed Care health plans identified the need for continuing to monitor provider availability in their own networks. Although most health plans had the number of primary care physicians (PCPs) and specialists required to operate, they admitted that many of these PCPs had closed panels and would not accept new patients. Ensuring that there is adequate access for all members, including new members, should be a priority for all health plans.
4. MO HealthNet Managed Care health plans identified improvement in their Quality Assessment and Improvement programs, and how this enhanced their ability to provide adequate and effective services to members. These efforts must be relentlessly continued to ensure that the organizations remain aware of areas for growth and improvement. These efforts ensure that the quality, timeliness and access to care required for member services is maintained as exceptional levels as health plans continued to struggle with recruitment of certain specialty physicians.
5. MO HealthNet Managed Care health plans identified the need for additional dental providers. Recruitment was largely delegated to subcontractors.

- Becoming actively involved in recruitment activities would benefit members and improve the quality of and access to care.
6. The use of data for quality improvement purposes and examination of healthcare outcomes has increased dramatically. Continued growth in the utilization of all of the data available to drive healthcare practice and initiatives is required to improve quality and access to care.

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2.0 VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS (PIPs)

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2.1 Definition

A Performance Improvement Project (PIP) is defined by the Centers for Medicare and Medicaid Services (CMS) as “a project designed to assess and improve processes, and outcomes of care...that is designed, conducted and reported in a methodologically sound manner.” The Validating Performance Improvement Projects Protocol specifies that the EQRO conduct three activities in the validation of two PIPs at each MO HealthNet Managed Care health plan that have been initiated, are underway, were completed during the reporting year, or some combination of these three stages. The State Medicaid Agency (SMA: the Department of Social Services, MO HealthNet Division) elected to examine projects that were underway during the preceding calendar year 2007. Criteria for identification of a PIP as outlined in the CMS protocols include the following:

- PIPs need to have a pre-test, intervention, and post-test
- PIPs need to control for extraneous factors
- PIPs need to include an entire population
- Pilot projects do not constitute a PIP
- Satisfaction studies alone do not constitute a PIP
- Focused studies are not PIPs: A focused study is designed to assess processes and outcomes on one-time basis, while the goal of a PIP is to improve processes and outcomes of care over time.

The State of Missouri contract for MO HealthNet Managed Care (C30611801-07) describes the following requirements for MO HealthNet Managed Care health plans in conducting PIPs:

Performance Improvement Projects: The health plan must conduct performance improvement projects that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. The health plan must report the status and results of each project to the state agency as requested. The performance improvement projects must involve the following:

- Measurement of performance using objective quality indicators.
- Implementation of system interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.
- Completion of the performance improvement project in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.
- Performance measures and topics for performance improvement projects specified by CMS in consultation with the state agency and other stakeholders.

2.2 Purpose and Objectives

The purpose and objectives of the present review were to evaluate the soundness and results of PIPs implemented by MO HealthNet Managed Care health plans during the calendar year 2007. The MO HealthNet Managed Care health plans were to have two active PIPs in place, one clinical and one nonclinical. The validation process examines the stability and variability in change over multiple years.

2.3 Technical Methods

There are three evaluation activities specified in the protocol for Validating Performance Improvement Projects. “Activity One: Assessing the MCOs/PIHPs Methodology for Conducting the PIP” consists of ten steps:

Activity One: Assessing the MCHPs /PIHPs Methodology for Conducting the PIP

1. Step One: Review the selected study topic(s)
2. Step Two: Review the study question(s)
3. Step Three: Review selected study indicator(s)

4. Step Four: Review the identified study population
5. Step Five: Review sampling methods (if sampling was used)
6. Step Six: Review the MCHPs/PIHPs data collection procedures
7. Step Seven: Assess the MCHPs /PIHPs improvement strategies
8. Step Eight: Review data analysis and interpretation of study results
9. Step Nine: Assess the likelihood that reported improvement is “real” improvement
10. Step Ten: Assess whether the MCHP/PIHP has sustained its documented improvement

“Activity Two: Verifying PIP Study Findings” is optional, and involves auditing PIP data. “Activity Three: Evaluate Overall Reliability and Validity of Study Findings” involves assessing whether the results and conclusions drawn from the PIP are valid and reliable. Activities One and Three were conducted by the EQRO.

TIME FRAME AND SELECTION

Two projects that were underway during the preceding 12 months at each MO HealthNet Managed Care health plan were selected for validation. The projects to be validated were reviewed with SMA and EQRO staff, in November 2007. The intent was to identify projects which were mature enough for validation (i.e., planned and in the initial stages of implementation), underway or completed during calendar year 2007. The SMA made the final decision regarding the actual PIPs to be validated from the descriptions submitted by the MO HealthNet Managed Care health plans.

PREPARATION OF MO HEALTHNET MANAGED CARE HEALTH PLANS

All health plans were contacted during November 2007 to prepare them for the 2007 External Quality Review. All health plans’ quality management staff or plan administrators were contacted to discuss the onset of the External Quality Review Organization (EQRO) activities and to schedule training teleconferences in December. The health plans were explicitly requested to have all staff or

subcontractors available who would be responsible for obtaining and submitting the data required to complete all validation processes. During these teleconferences, all aspects of the EQR, including the requirements of submissions for the Performance Improvement Projects, were discussed.

The training teleconference agenda, methods and objectives, and schedule were sent to all health plans, following approval from the State Medicaid Agency (SMA), in early November 2007. SMA staff agreed to participate in these conference calls, allowing time for presentation of information, clarification, and questions. The original submission of Performance Improvement Project subjects was scheduled prior to the end of November 2007. Submission of data was scheduled for February through March 2008. This allowed for completion of all 2007 activities and compilation of initial data for projects underway in the previous year.

REVIEWERS

Three reviewers conducted the Validating Performance Improvement Project Protocol activities, including interviews and document review. The External Quality Review Organization (EQRO) Project Director is a licensed attorney with a graduate degree in Health Care Administration, and seven years of experience in public health and managed care in two states. This was her third review. She conducted interviews and provided oversight to the PIP Protocol team. The Assistant Project Director was conducting her fourth review. She has experience with the MO HealthNet Managed Care Program implementation and operations, interviewing, program analysis, and Medicaid managed care programs in other states, and thirteen years experience in program evaluation and research. The third reviewer participated in seven previous MO HealthNet Managed Care Program reviews and on-site visits. This reviewer was knowledgeable about the MO HealthNet Managed Care Program through her experience as a former SMA employee responsible for quality assessment and improvements, as an RN, and a consultant. All reviewers were familiar with the program improvement project requirements and validation process, as well as research methods, and the requirements of the MO HealthNet Managed Care Program.

2.4 Procedures for Data Collection

The evaluation involved review of all materials submitted by the MO HealthNet Managed Care health plans including, but not limited to, the materials listed below. During the training teleconferences the health plans were encouraged to review Attachment B of the Validating Performance Improvement Projects Protocol and ensure that they include supporting documents, tools, and other information necessary to evaluate the projects submitted, based on this tool.

- Narrative descriptions
- Problem identification
- Hypotheses
- Study questions

- Description of interventions(s)
- Methods of sampling
- Planned analysis
- Sample tools, measures, survey, etc.
- Baseline data source and data
- Cover letter with clarifying information
- Overall analysis of the validity and reliability of each study
- Evaluation of the results of the PIPs

The EQRO Project Director, Assistant Project Director, and Review Consultant met with the MO HealthNet Managed Care health plan staff responsible for planning, conducting, and interpreting the findings of the PIPs during the on-site reviews occurring between July and August 2008. The review focused on the findings of projects conducted during 2007. The health plans were instructed that additional information and data not available at the time of the original submission could be provided at the time of the on-site review or shortly thereafter. The time scheduled during the on-site review was utilized to conduct follow-up questions, to review data obtained, and to provide technical assistance to health plans regarding the planning, implementation and credibility of findings from PIPs. In addition, individual clarifying questions were used to gather more information regarding the PIPs. The following questions were formulated and answered in the original documentation, or were posed to the health plans during the on-site review:

- Who was the project leader?
- How was the topic identified?
- How was the study question determined?
- What were the findings?
- What were the interventions(s)?
- What was the time period of the study?
- Was the intervention effective?
- What did the MO HealthNet Managed Care health plan want to learn from the study?

All PIPs were evaluated by the Review Consultant and the Assistant Project Director. In addition, the projects were reviewed with follow-up suggestions posed by the Project Director, who approved final ratings based on all information available to the team.

ANALYSIS

All PIPs submitted by MO HealthNet Managed Care health plans prior to the site visits were reviewed using an expanded version of the checklist for conducting Activity One, Steps 1 through 10, and Activity Three (Judgment of the Validity and Reliability of the PIPs) of the Validating Performance Improvement Projects Protocol, Attachment B (see Appendix 2). Because certain criteria may not have been applicable for projects that were underway at the time of the review, some specific items were considered as “Not Applicable.” Criteria were rated as “Met” if the item was applicable to the PIP, if there was documentation addressing the item, and if the item could be deemed “Met” based on the study design. The proportion of items rated as “Met” was compared to the total number of items that were applicable for the particular PIP. Given that some PIPs were underway in the first year of implementation, it was not possible to judge or interpret: results; validity of improvement; or sustained improvements (Steps 8-10). The final evaluation of the validity and reliability of studies was based on the potential for the studies to produce credible findings. Detailed recommendations and suggestions for improvement were made for each item where appropriate, and are presented in the individual health plan summaries. Some items are rated as “Met” but continue to include suggestions and recommendations as a method of improving the information presented. The following are the general definitions of the ratings developed for evaluating the PIPs.

Met:	Credible, reliable, and valid methods for the item were documented.
Partially Met :	Credible, reliable, or valid methods were implied or able to be established for part of the item.
Not Met:	The study did not provide enough documentation to determine whether credible, reliable,

Not Applicable:

and valid methods were employed; errors in logic were noted; or contradictory information was presented or interpreted erroneously.

Only to be used in Step 5, when there is clear indication that the entire population was included in the study and no sampling was conducted; or in Steps 8 through 10 when the study period was underway for the first year.

2.5 Findings

Below are the PIPs identified for validation at each MO HealthNet Managed Care health plan:

Blue-Advantage Plus	<p>Ambulatory Follow-Up After Hospitalization for Mental Health Disorders</p> <p>Training, Education and Restructuring the Work Flow of Member Grievances/Appeals, and Provider Complaints, Grievances/Appeals to Improve the Response Time to Members and Providers</p>
Children's Mercy Family Health Partners	<p>Improving Non-Emergency Transportation Services</p> <p>Improving Well-Child Visits First 15 months of Life</p>
Harmony Health Plan	<p>Lead Screening</p> <p>Medical Record Documentation by Primary Care Physicians (PCPs) and Their Staff/Interventions and Their Efficacy</p>
HealthCare USA	<p>Improving post-discharge management of members discharged from an inpatient service for mental illness</p> <p>Appeals and Grievances</p>
Mercy CarePlus	<p>Emergency Room Utilization</p> <p>Early Intervention in Prenatal Care Management and the Relationship to the Very Low Birth Weight Babies</p>
Missouri Care	<p>Increase Asthma Management</p> <p>Seven-day Follow-up Following Hospitalization for Mental Illness</p>

STEP 1: SELECTED STUDY TOPICS

Study topics were selected through data collection and the analysis of comprehensive aspects of member needs, care, and services; and to address a broad spectrum of key aspects of member care and services. In all cases they included all enrolled populations pertinent to the study topic without excluding certain members. Three of the 12 PIPs addressed follow-up care after discharge from hospitalization from mental illness; one addressed care for members with asthma and one addressed lead screening; one addressed access to care for pregnant members with the goal of reducing low birth weight infants; one addressed emergency room utilization; one addressed improving well-child visits in the first 15 months of life; two addressed improving the grievance and appeal process and one addressed transportation issues that led to grievances and appeals; and one addressed medical record documentation.

Table 1 shows the ratings for each item and PIP by MO HealthNet Managed Care health plan. Table 2 summarizes the Performance Improvement Project validation ratings by item. The information provided in all 12 PIPs included a sound rationale that demonstrated the need for the PIP and support for the selection of the study topic. These project narratives all discussed literature supporting the activities to be undertaken and related the broad research reviewed to pertinent local issues. The narratives reviewed also provided some benchmark comparison data. While this section was not entirely perfect the health plans met all the criteria required 91.67% of the time. Each PIP addressed a broad spectrum of the key aspects of member care and services (100% Met this criteria; Step 1.2). Each health plan submitted one clinical and one non-clinical intervention for review. An array of aspects of enrollee care and services that were related to the identified problem was described. Utilization or cost issues may be examined through a PIP, but were not the sole focus of any study. There were adequate descriptions of the member populations targeted for intervention in the PIPs. During past reviews it was difficult to determine if the member populations addressed by the PIPs were MO HealthNet members, due to the variety of populations served by the health plans (e.g., other state's Medicaid

managed care members, commercial members, or Medicare members). The PIPs reviewed for 2007 did address MO HealthNet members exclusively, by all but one health plan. In addition, PIPs should specifically indicate whether all enrolled populations within the MO HealthNet Managed Care Program were included in the interventions. Finally, age and demographic characteristics should be described. All twelve of the PIPs (100%) Met these criteria (Step 1.3).

Table 1 – Performance Improvement Project Validation Findings by MO HealthNet Managed Care Health Plan

Step	Item	MO HealthNet Managed Care Health Plans											
		BA +		CMFHP		Harmony		HCUSA		MCP		MOCare	
		Ambulatory Follow-Up After Mental Health Hospitalization	Appeals Process Compliance	Well-Child Visits in First 15 Months	Improving Non-Emergency/Transportation Services	Lead Screening	Medical Record Review	Appeals and Grievances	Post-Discharge Management after Inpatient Mental Health Treatment	Emergency Department Utilization	Early Intervention in Prenatal Case Management	Asthma Management	7-Day Follow-Up After Hospitalization for Mental Illness
Step 1: Selected Study Topics	1.1	1	2	2	2	2	2	2	2	2	2	2	2
	1.2	2	2	2	2	2	2	2	2	2	2	2	2
	1.3	2	2	2	2	2	2	2	2	2	2	2	2
Step 2: Study Questions	2.1	2	2	2	2	2	2	2	2	2	2	2	2
Step 3: Study Indicators	3.1	2	2	2	2	2	2	2	2	1	2	2	2
	3.2	2	2	2	2	2	2	2	2	1	2	2	2
Step 4: Study Populations	4.1	2	2	2	2	2	2	2	2	2	2	2	2
	4.2	2	2	2	2	2	2	2	2	1	2	2	2
Step 5: Sampling Methods	5.1	NA	NA	NA	NA	NA	2	NA	NA	NA	NA	NA	NA
	5.2	NA	NA	NA	NA	NA	2	NA	NA	NA	NA	NA	NA
	5.3	NA	NA	NA	NA	NA	2	NA	NA	NA	NA	NA	NA
Step 6: Data Collection Procedures	6.1	2	2	2	2	2	2	2	2	2	2	2	2
	6.2	2	2	2	2	2	2	2	2	1	2	2	2
	6.3	2	2	2	2	2	2	2	2	1	2	2	2
	6.4	2	2	2	2	1	2	2	2	1	2	2	2
	6.5	2	2	2	2	1	2	2	2	1	2	2	2
	6.6	2	2	2	2	2	2	2	2	2	2	2	2
Step 7: Improvement Strategies	7.1	2	2	2	2	2	2	2	2	2	2	2	2
Step 8: Analysis and Interpretation of Study Results	8.1	2	2	2	2	NA	2	2	2	2	2	2	2
	8.2	2	2	2	2	NA	NA	2	2	2	2	2	2
	8.3	2	2	2	2	NA	NA	2	2	1	1	2	2
	8.4	2	2	2	2	NA	NA	2	2	1	2	2	2
Step 9: Validity of Improvement	9.1	NA	NA	NA	2	NA	NA	2	2	NA	2	2	2
	9.2	NA	NA	NA	2	NA	NA	NA	2	NA	1	2	2
	9.3	NA	NA	NA	2	NA	NA	NA	2	NA	2	2	2
	9.4	NA	NA	NA	2	NA	NA	NA	2	NA	1	2	2
Improvement	10	NA	NA	NA	NA	NA	NA	NA	1	NA	2	2	2
Number Met		18	19	19	23	13	19	20	23	10	21	24	24
Number Partially Met		1	0	0	0	2	0	0	1	9	3	0	0
Number Not Met		0	0	0	0	0	0	0	0	0	0	0	0
Number Applicable		19	19	19	23	15	19	20	24	19	24	24	24
Rate Met		94.7%	100.0%	100.0%	100.0%	86.7%	100.0%	100.0%	95.8%	52.6%	87.5%	100.0%	100.0%

Note: Rate Met = Number Met/Number Applicable; 2 = Met; 1 = Partially Met ; 0 = Not Met; NA = Not Applicable; Item refers to the Protocol specifications.

Source: BHC, Inc., 2007 External Quality Review Performance Improvement Project Validation.



STEP 2: STUDY QUESTIONS

Study questions are statements in the form of a question that describe the potential relationship between the intervention, the intended outcome, and the data to be obtained and analyzed. The questions must be specific enough to suggest the study methods and outcome measures. The health plans made a concerted effort to ensure that statements were provided in the form of a question, and in all cases the questions were directly related to the hypotheses and topic selected. Twelve (100%) of the PIPs included clearly stated study questions (Step 2.1). The study purposes identified were consistent with the remainder of the PIP (the target population, interventions, measures, or methods) in most instances.

Table 2- Summary of Performance Improvement Project Validation Ratings by Item, All MCHPs

Step	All MC+ MCOs					
	Item	Number Met	Number Partially Met	Number Not Met	Total Number Applicable	Rate Met
Step 1: Selected Study Topics	1.1	11	1	0	12	91.67%
	1.2	12	0	0	12	100.00%
	1.3	12	0	0	12	100.00%
Step 2: Study Questions	2.1	12	0	0	12	100.00%
Step 3: Study Indicators	3.1	11	1	0	12	91.67%
	3.2	11	1	0	12	91.67%
Step 4: Study Populations	4.1	12	0	0	12	100.00%
	4.2	11	1	0	12	91.67%
Step 5: Sampling Methods	5.1	1	0	0	1	100.00%
	5.2	1	0	0	1	100.00%
	5.3	1	0	0	1	100.00%
Step 6: Data Collection Procedures	6.1	12	0	0	12	100.00%
	6.2	11	1	0	12	91.67%
	6.3	11	1	0	12	91.67%
	6.4	10	2	0	12	83.33%
	6.5	10	2	0	12	83.33%
	6.6	12	0	0	12	100.00%
Step 7: Improvement Strategies	7.1	12	0	0	12	100.00%
Step 8: Analysis and Interpretation of Study Results	8.1	11	0	0	11	100.00%
	8.2	10	0	0	10	100.00%
	8.3	8	2	0	10	80.00%
	8.4	9	1	0	10	90.00%
Step 9: Validity of Improvement	9.1	6	0	0	6	100.00%
	9.2	4	1	0	5	80.00%
	9.3	5	0	0	5	100.00%
	9.4	4	1	0	5	80.00%
Step 10: Sustained Improvement	10.1	3	1	0	4	75.00%
Number Met		233	16	0	249	93.57%

Note: Percent Met = Number Met/ Number Applicable; Item refers to the Protocol specifications

Note: Percent Met = Number Met/ Number Applicable; Item refers to the Protocol specifications

Source: BHC, Inc., 2007 External Quality Review Performance Improvement Project Validation

STEP 3: STUDY INDICATORS

A majority of the PIPs “Met” the criteria for defining and describing the calculation of study indicators. Eleven (91.67%) of the PIPs Met the criteria for using objective, clearly defined, measurable indicators while one was rated as Partially Met (Step 3.1). The calculation of measures was described and explained. Even when well-known measures were used (e.g., Health Employer Data Information Set; HEDIS; Consumer Assessment of Health Plans Survey; CAHPS), there was a detailed description of the methods (e.g., Administrative or Hybrid Method) and formulas for calculating the measures. Again, because the health plans vary in their method of calculation, details regarding the measures and methods of calculating those measures should be included in PIPs. All but one of the 12 PIPs identified and detailed at least one study indicator that was related to health or functional status; or to processes of care strongly associated with outcomes. Eleven of the 12 (91.67%) were rated as “Met” (Step 3.2); and one was Partially Met. The link between the intervention and the outcomes measured by the PIP should be explicit in the narrative.

STEP 4: STUDY POPULATIONS

The health plans all made an attempt to meet the criteria for adequately defining the study population. The evaluation examines if all the MO HealthNet Managed Care Program Members to whom the study question(s) and indicator(s) were relevant are included. All twelve PIPs (100%) did include adequate information to make this determination (Step 4.1). All PIPs, including those considered non-clinical, defined the applicable study population being considered. The selection criteria should clearly describe the MO HealthNet Managed Care Member populations included in the PIP and their demographic characteristics. Eleven of the 12 PIPs (92%) described data collection approaches indicating that data for all members to whom the study question applied were collected (Step 4.2). In all cases there was a

description that at least allowed inference of how data were collected and how members were identified.

STEP 5: SAMPLING METHODS

Sampling techniques were utilized in one of the PIPs reviewed. The health plan (Harmony Health Plan of Missouri) employed true sampling techniques. The type of sample (e.g., convenience, random) or sampling methods (e.g., simple, cluster, stratified) were described in detail. All required criteria for correct use of a sampling methodology were included.

STEP 6: DATA COLLECTION PROCEDURES

All twelve (12) of the PIPs described the data to be collected with adequate detail and a description of the units of measurement used (Step 6.1). Eleven of 12 (91.67%) PIPs clearly specified the sources of data (e.g., claims, members, providers, medical records) for each measure (Step 6.2). Some health plans used the National Committee for Quality Assurance (NCQA) Quality Improvement Activity (QIA) Form to write up their PIP narrative. This form provides a structure for reporting measures and data sources. However, when there is more than one source of data, it is important that the health plan specifically states the sources of data for each measure. The health plans were reminded that the strict use of this format limits the narrative and explanation that must accompany the PIP in order for the EQRO to validate each element. Eleven of 12 PIPs (91.67%) clearly described systematic and reliable methods of data collection (Step 6.3). There was some description of the data collection procedures in all cases. It is not possible to judge the reliability or credibility of any PIP without sufficient detail regarding data collection processes, procedures, or frequency. Eleven of the PIPs used a data collection instrument that was described in detail. Eleven provided information on the methods or instruments to be used to collect data. In one case the information was not presented in a method which allowed that consistent and accurate data would be collected over time (Step 6.4). In one case the health plan did not provide adequate information to determine if accurate data would be collected over time. However, ten (83.33%) “Met” this element, while two “Partially Met” this element.

When using surveys, medical records, or telephone protocols for data collection, it is important to provide the tool for review, discuss the piloting of the tool, and discuss training and interrater reliability for the recording of information on the tool.

Standard provider and consumer surveys provide manuals describing the characteristics of instruments that should be incorporated into the narrative of the PIP. A sufficient level of detail, including sample copies of instruments utilized, was provided in the narrative for all PIPs. The PIPs provided the parameters for the

calculation of these measures and included sufficient information to make a judgment for this validation element.

Ten of the PIPs (83.33%) included a complete data analysis plan, while two additional PIPs were rated Partially Met for specifying a plan (Step 6.5). All PIP narratives included some information that prospectively specified a data analysis plan. This plan should be developed prior to the implementation of the PIP, be based on the study questions, explain the expected relation between the intervention(s) and outcome(s) being measured (i.e. independent and dependent variables), and include the method(s) of data collection, and the nature of the data (e.g., nominal, ordinal, scale).

All twelve PIPs identified the project leaders, the staff involved in the PIP, and their qualifications in the narrative submitted. They also identified who was involved in or provided oversight for the design, implementation, data analysis, and interpretation of the PIP (Step 6.6). Health plan staff interviewed on-site included team members who were involved and knowledgeable about the PIPs and methods. Additional information about all the PIP team members and their qualifications and roles were not originally provided in the narrative, but were clarified with the submission of additional information after the time of the on-site review. This information provided additional clarification and validity to the process and the measures.

STEP 7: IMPROVEMENT STRATEGIES

All twelve (100%) of the PIPs identified reasonable interventions to address the barriers identified through data analysis and quality improvement processes undertaken. The nature of identification of the barriers, a description of barriers, and a plan for addressing barriers was described and discussed during the on-site review.

STEP 8: DATA ANALYSIS AND INTERPRETATION OF STUDY RESULTS

Ten of the 12 PIPs were mature enough to present data to analyze. These health plans (100%) conducted their analyses according to the data analysis plan (Step 8.1). Of the ten PIPs that presented baseline or re-measurement data, they each (100%) presented numerical findings accurately and clearly (Step 8.2). In some instances, data were presented in formats that originally lacked explanatory narrative. This issue was discussed with the health plans at the on-site review. Revisions and updates were received that provided adequate explanation of data and the information presented. Axis labels and units of measurement should be reported in Table and in Figure legends. This information should be clearly identifiable to the reader.

Of the ten PIPs that presented at least one re-measurement period, eight (80.0%) indicated the re-measurement period for all of the measures identified in the study (Step 8.3). Of the ten PIPs describing the findings, nine (90.0%) described the extent to which the intervention was effective (Step 8.4).

STEP 9: VALIDITY OF IMPROVEMENT

Six PIPs (100%) with re-measurement points used the same method at re-measurement as the baseline measurement (Step 9.1). Whenever possible the baseline measure should be recalculated consistent with the re-measurement method to ensure validity of reported improvement and comparability of measurement over time. One PIP did explain that the MO HealthNet eligibility criteria changed during the measurement year. How this change was incorporated into the baseline information was clearly explained and documented. The same source of measures should also be used at re-measurement points. Four of the five PIPs (80%) that were mature enough to include data analysis employed statistical significance testing to document quantitative improvements in care (Step 9.2). They were able to show significant improvement over multiple re-measurement points, however, this improvement was not always statistically significant. These five (100%) PIPs reported improvements that had face validity, meaning that the reported improvement was judged to have been related to the intervention applied (Step 9.3). These PIPs provided some discussion or interpretation of findings by health plans. Additional narrative in this area would ensure proper evaluation of all data and information provided. This was another area that improved after providing technical assistance at the time of the on-site review. The need for narrative summaries of the information and data provided was stressed with the health plans. After reporting findings, there should be some interpretation as to whether the intervention or other factors may have accounted for improvement, decline, or lack of change. Four of the five PIPs (80%) that had reached a level of maturity to include this data did provide statistical evidence that the observed improvement was true improvement (Step 9.4). Then, barriers should be identified and addressed for the next cycle of the PIP, or reasons for discontinuing the PIP should be described. It was suggested that the discussion of barriers be integrated into the discussion of each intervention. How identified barriers create unforeseen variables in the PIP outcomes was another factor that should be addressed in the narrative documentation presented for each PIP.

STEP 10: SUSTAINED IMPROVEMENT

Of the four PIPs examining multiple measurement points over time, three (75%) PIPs used statistical significance testing to demonstrate improvement. These three (75%) showed statistically significant improvement over several measurement points. One PIP (25%) did not provide adequate information to justify that any sustained improvement would occur. The low numbers in this area are a function of the lack of maturity that many of the PIPs exhibited. The PIPs that did indicate that there was observed improvement as the result of the interventions provided through this process all included statements that these interventions will become part of the health plans' regular operations.

2.6 Conclusions

Across all health plans, the range in proportion of criteria that were "Met" for each PIP validated was 52.6% through 100% (See Table 1). This compares to a rate of 25.0% through 100% in 2006. Across all PIPs validated statewide, 93.57% of criteria were met which indicates a significant increase over the 2006 rate of 75.0%. It should also be noted that the results in 2007 reflect statistics for twelve PIPs reviewed, while the 2006 results reflect ten PIPs reviewed. The quality and depth of the PIPs submitted reflect a continued commitment and improvement to the Performance Improvement Project process throughout all of the MO HealthNet Managed Care health plans. All sources of available data were used to develop the ratings for the PIP items. The EQRO comments were developed based on the written documentation and presentation of findings. In all cases, there was enough information provided to validate the PIPs. On-site interviews and subsequent information provided revealed the depth of commitment the majority of the health plans have developed in utilizing the PIP process to improve organizational process and outcomes.

All of the PIPs presented included thoughtful and complex information. In some of the PIPs, enhanced information obtained at the on-site review, made it clear that

the health plan intended to use this process to improve organizational functions and the quality of services available or delivered to members. In several cases the performance improvement project had already been incorporated into health plan daily operations. PIPs are to be ongoing, with periodic re-measurement points. At least quarterly re-measurement is recommended to provide timely feedback to the MO HealthNet MCHP regarding the need to address barriers to implementation. Health plan personnel involved in PIPs had extensive experience in clinical service delivery, quality improvement, and monitoring activities. It was clear that they had made a significant improvement and investment in designing valid evaluation studies using sound data collection and analysis methods. This requires technical expertise in health services research and/or program evaluation design.

Based on the PIP validation process, at least four health plans (Children's Mercy Family Health Partners, Blue-Advantage Plus of Kansas City, HealthCare USA, and Missouri Care) had active and ongoing PIPs as part of their quality improvement programs. One health plan (Mercy CarePlus) continues to improve their utilization of the PIP process as a tool to develop their performance and improve services to members. Harmony Health Plan of Missouri submitted PIPs for review for the first time during this External Quality Review. HHP's interventions included projects that are ongoing in both their Missouri and Illinois operations. The quality of HHP's PIPs indicated a thorough understanding of the use of the performance improvement project as method of enhancing and improving member services. A continually improving commitment to the quality improvement process was observed during the on-site review at each health plan. With each submission it is noted that the complexity and maturity of the PIP process has improved from prior submissions. This is further evidence that the performance improvement project process has become an integral part of all MO HealthNet Managed Care health plans' operations.

Table 3 - Validity and Reliability of Performance Improvement Project Results

PIP Name	Rating
Emergency Room Utilization	Moderate Confidence
Early Intervention in Prenatal Care Management	High Confidence

Appeals and Grievances	Moderate Confidence
Post-Discharge Management after Inpatient Mental Health Treatment	High Confidence
Lead Screening	Moderate Confidence
Medical Record Review	Moderate Confidence
Appropriate Use of Asthma Medications	High Confidence
7-Day Follow-Up After Hospitalization for Mental Illness	High Confidence
Well-Child Visits in the First 15 Months of Life	Moderate Confidence
Improving Non-Emergency Transportation Services	High Confidence
Ambulatory Follow-Up After Mental Health Hospitalization	Moderate Confidence
Appeals Process Compliance	Moderate Confidence

Note: Not Credible = There is little evidence that the study will or did produce results that could be attributed to the intervention(s); Low Confidence = Few aspects of the PIP were described or performed in a manner that would produce some confidence that findings could be attributed to the intervention(s); Moderate Confidence = Many aspects of the PIP were described or performed in a manner that would produce some confidence that findings could be attributed to the intervention(s); High Confidence = The PIP study was conducted or planned in a methodologically sound manner, with internal and external validity, standard measurement, and data collection practices, and appropriate analyses to calculate that there is a high level of confidence that improvements were a result of the intervention. A 95% to 99% level of confidence in the findings was or may be able to be demonstrated. Source: BHC, Inc., 2007 External Quality Review Performance Improvement Project Validation

Table 3 indicates the overall confidence rating for all of the PIPs submitted. This

table reflects an improvement in the confidence levels achieved in the 2006 PIPs.

The following summarizes the quality, access, and timeliness of care assessed during this review, and recommendations based on the findings of the Validation of Performance Improvement Projects activity.

ACCESS TO CARE

Access to care was an important theme addressed throughout all the PIP submissions reviewed. Five of the PIPs utilized enhanced case management procedures to ensure that members had access to care, were reminded of appointments, and that case managers were available to ensure that barriers to services were decreased. Two health plans focused on education and support to

obtain appropriate services and medications for the treatment of asthma and access to lead screening (Missouri Care and Harmony Health Plan). All the projects reviewed used the format of the PIP to improve access to care for members. Three of the projects clearly focused on ensuring the members had adequate and timely access to services after being hospitalized for mental health related issues (HealthCare USA, Missouri Care, BA+). The on-site discussions with health plan staff indicate the realization that improving access to care is an ongoing aspect of all projects that are developed. One health plan (Mercy CarePlus), developed an ongoing PIP into a project that provides case management services to all pregnant members. As outcome data are finalized, and as an example of both improved access and quality of care, this project should become a best practice to be shared throughout the health plans.

QUALITY OF CARE

Topic identification was an area that provided evidence of the attention placed on providing quality services to members. Intervention development for PIPs also focused on the issue of quality services. All PIPs reviewed focused on topics that needed improvement, either in the internal processes used to operate the health plan, or in the direct provision of services delivered. The corresponding interventions that address barriers to quality care and health outcomes were clearly evident in the narratives submitted. There was further evidence of a commitment to quality of care during on-site discussion at each health plan, including the desire to supply supplemental and updated information to ensure that project efforts and outcomes were clearly reported. These interventions addressed key aspects of enrollee care and services, such as medication and treatment management; risk identification and stratification for various levels of care; monitoring provider access and quality services; and preventive care. These efforts exemplified an attention to quality healthcare services.

TIMELINESS OF CARE

Timeliness of care was the major focus of a number of the PIPs reviewed. Three projects identified the need for timely aftercare for members who required inpatient hospitalization for mental illness (HealthCare USA, Missouri Care, and BA+). The remaining projects focused on subjects such as timely processing and resolution of grievances and appeals (HealthCare USA, and BA+), appropriate medications and treatment for asthma (Missouri Care), improved access to non emergent transportation services (Children's Mercy Family Health Partners), improved access to well-child visits in the first 15 months of life (Children's Mercy Family Health Partners). All addressed the need for timely access to preventive and primary health care services. The health plans all related their awareness of the need to provide not only quality, but timely services to members. Projects reflected this awareness in that they addressed internal processes and direct service improvement.

RECOMMENDATIONS

1. It is recommended that health plans continue to refine their skills in the development and implementation of the Performance Improvement Projects. Improved training, assistance and expertise for the design, statistical analysis, and interpretation of PIP findings are available. One health plan (Children's Mercy Family Health Partners) continues to utilize the services of a statistician from a local university to ensure valid and reliable findings.
2. In the design of PIPs, the health plans need to use generally accepted practices for program evaluation to conduct PIPs. In addition to training on the development of PIPs and on-site technical assistance, references to the CMS protocol, "[Conducting Performance Improvement Projects](#)" were recommended by the EQRO at each health plan as a guideline to frame the development, reporting and analysis of the PIP.
3. PIPs should be conducted on an ongoing basis, with at least quarterly measurement of some indices to provide data about the need for changes in implementation, data collection, or interventions.

4. PIPs that are not yet complete should include narrative reflecting next steps and a plan for how the PIP will be maintained and enhanced for future years.
5. It appears that in most instances the health plans conduct PIPs on an ongoing basis as part of their quality improvement program. Continuing to utilize these PIPs as tools to improve the organizations' ability to serve members is beneficial.

3.0 VALIDATION OF PERFORMANCE MEASURES

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3.1 Definition

The EQRO is required by the Validating Performance Measures Protocol to evaluate three performance measures reported by each MO HealthNet MCHP. These measures are selected by the State Medicaid Agency each year (SMA; the Missouri Department of Social Services MO HealthNet Division; MHD). For the HEDIS 2007 evaluation period, the three performance measures selected for validation were Annual Dental Visits (ADV), Adolescent Well-Care Visits (AWC), and Follow-Up After Hospitalization for Mental Illness (FUH). Protocol activities performed by the EQRO for this audit included: 1) Review of the processes used by the MO HealthNet health plans to analyze data; 2) Evaluation of algorithmic compliance with performance measure specifications; and 3) Recalculation of either the entire set of performance measure data (administrative rates) or a subset of the data (hybrid rates) to verify and confirm the rates reported by the health plans are based upon accurate calculations.

3.2 Purpose and Objectives

The objectives for validating performance measures were to: 1) evaluate the accuracy of Medicaid performance measures reported by, or on behalf of, MO HealthNet Managed Care health plans; and 2) determine the extent to which MO HealthNet Managed Care health plan-specific performance measures calculated by the health plans (or by entities acting on behalf of the health plans) followed specifications established by the SMA and the State Public Health Agency (SPHA; Missouri Department of Health and Senior Services; DHSS) for the calculation of the performance measure(s).

REVIEWERS

Interviews, document review, and data analysis activities for the Validating Performance Measure Protocol were performed by two reviewers from the External Quality Review Organization (EQRO). The Project Director conducted interviews and document review; she is a licensed attorney with a graduate degree in Health

Care Administration, as well as seven years experience in public health and managed care in two states. This is her third External Quality Review. Data analysis and interviews were conducted by the EQRO Research Analyst, who is an Information Technology specialist with a Bachelors Degree in Computer Science and a Masters Degree in Business Administration. She has worked for over four years managing data in large and small databases.

3.3 Technical Methods

Reliable and valid calculation of performance measures is a critical component to the EQRO audit. These calculations are necessary to calculate statewide rates, compare the performance of MO HealthNet Managed Care health plans with other MO HealthNet Managed Care health plans, and to compare State and health plan performance with national benchmarked data for Medicaid Managed Care and/or Commercial Managed Care Organization members. These types of comparisons allow for better evaluation of program effectiveness and access to care. The EQRO reviewed the selected data to assess adherence to State of Missouri requirements for MO HealthNet Managed Care health plan performance measurement and reporting. The Missouri Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) contains provisions requiring all Health Maintenance Organizations (HMOs) operating in the State of Missouri to submit to the SPHA member satisfaction survey findings and quality indicator data in formats conforming to the National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS) Data Submission Tool (DST) and all other HEDIS Technical Specifications⁹ for performance measure descriptions and calculations. The State of Missouri contract for MO HealthNet Managed Care (C30611801-07, Revised Attachment 6, Quality Improvement Strategy) further stipulates that MO HealthNet health plans will follow the instructions of the SPHA for submission of HEDIS measures. The three measures selected by the SMA for validation were required to be calculated and reported by MO HealthNet Managed Care health plans to both the SMA and the SPHA for MO HealthNet

⁹ National Committee for Quality Assurance. HEDIS 2007, Volume 2: Technical Specifications. Washington, D.C.: NCQA.

Managed Care Members. A review was conducted for each of the three measures selected based upon the HEDIS 2007 Technical Specifications. These specifications are provided in the following tables:

HEDIS 2007 ADOLESCENT WELL-CARE VISITS (AWC)

The following is the definition of the Adolescent Well-Care Visits measure, a Use of Services measure¹⁰, and the specific parameters as defined by the NCQA.

The percentage of enrolled members who were 12–21 years of age and who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.

Table 4 - HEDIS 2007 Technical Specifications for Adolescent Well-Care Visits (AWC)

I. Eligible Population	
Product lines	Commercial, Medicaid (report each product line separately).
Ages	12–21 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	Members who have had no more than 1 gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.
II. Administrative Specification	
Denominator	The eligible population.
Numerators	At least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year. The primary care practitioner does not have to be assigned to the member. Adolescents who had a claim or encounter with a primary care practitioner or OB/GYN practitioner with one of the codes listed below are considered to have received a comprehensive well-care visit: 99383-99385, 99393-99395, V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

¹⁰ This measure has the same structure as measures in the Effectiveness of Care domain. The MCO should follow *Specific Guidelines for Effectiveness of Care Measures* when calculating this measure.

III. Hybrid Specification

Denominator A systematic sample drawn from the MCO's eligible population. The MCO may reduce its sample size using the current year's administrative rate or the prior year's audited, product line-specific rate.

Note: For information on reducing sample size, refer to the Guidelines for Calculations and Sampling.

Numerators At least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year, as documented through either administrative data or medical record review.

The primary care practitioner does not have to be assigned to the member.

Administrative Refer to the *Administrative Specification* listed above to identify positive numerator hits from the administrative data.

Medical record Documentation in the medical record must include, a note indicating a visit to a primary care practitioner or OB/GYN practitioner, the date on which the well-care visit occurred and, evidence of all of the following.

- A health and developmental history (physical and mental)
- A physical exam
- Health education/anticipatory guidance

An MCHP that submits HEDIS data to NCQA must provide the following data elements:

Table 5 - Data Elements for Adolescent Well-Care Visits

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (administrative or hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		✓
Current year's administrative rate (before exclusions)		✓
Minimum required sample size (MRSS) or other sample size		✓
Oversampling rate		✓
Final sample size (FSS)		✓
Number of numerator events by administrative data in FSS		✓
Administrative rate on FSS		✓
Number of original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical record data records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Reported rate	✓	✓
Lower 95% confidence interval	✓	✓
Upper 95% confidence interval	✓	✓

HEDIS 2007 FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS (FUH)

The following is the definition of the Follow-Up After Hospitalization for Mental Illness measure, an Effectiveness of Care measure, and the specific parameters as defined by the NCQA.

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who were seen on an outpatient basis or were in intermediate treatment with a mental health provider.

Table 6 - HEDIS 2007 Technical Specifications for Follow-Up After Hospitalization for Mental Illness (FUH)

I. Eligible Population	
Product lines	<i>Commercial, Medicaid, Medicare (report each product line separately).</i>
Ages	<i>6 years and older as of the date of discharge.</i>
Continuous enrollment	<i>Date of discharge through 30 days after discharge.</i>
Allowable gap	<i>No gaps in enrollment.</i>
Anchor date	<i>None.</i>
Benefits	<i>Medical and mental health (inpatient and outpatient).</i>
Event/diagnosis	<p><i>Discharged from an inpatient setting of an acute care facility (including acute care psychiatric facilities) with a discharge date occurring on or before December 1 of the measurement year and a principal ICD-9-CM Diagnosis code indicating a mental health disorder specified below:</i></p> <p>295–299, 300.3, 300.4, 301, 308, 309, 311–314, 426, 430</p> <p><i>The MCO should not count discharges from nonacute care facilities (e.g., residential care or rehabilitation stays).</i></p>
Multiple discharges	<i>A member with more than one discharge on or before December 1 of the measurement year with a principal diagnosis of a mental health disorder (Table FUH-A) could be counted more than once in the eligible population.</i>

Mental health readmission or direct transfer	<p><i>If the discharge for a selected mental health disorder is followed by readmission or direct transfer to an acute facility for any mental health principal diagnosis within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred.</i></p> <p><i>Although rehospitalization might not be for a selected mental health disorder, it is probably for a related condition. Only readmissions with a discharge date that occurs on or before December 1 of the measurement year are included in the measure. Refer to the ICD-9-CM codes listed in Table MIP-A.</i></p> <p><i>Exclude discharges followed by readmission or direct transfer to a nonacute facility for any mental health principal diagnosis within the 30-day follow-up period. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place. (Refer to Table NON-A for codes to identify nonacute care.)</i></p>
Non-mental health readmission or direct transfer	<i>Exclude discharges in which the patient was transferred directly or readmitted within 30 days after discharge to an acute or nonacute facility for a non-mental health principal diagnosis. These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit.</i>
Denied claims	<i>Denials of inpatient care (e.g., those resulting from members failing to get proper authorization) are not excluded from the measure.</i>

II. Administrative Specification

Denominator	<p>The eligible population.</p> <p>Note: <i>The eligible population for this measure is based on discharges, not members. It is possible for the denominator for this measure to contain multiple discharge records for the same individual.</i></p>
Numerators	<p>An outpatient mental health encounter or intermediate treatment with a mental health practitioner within the specified time period. For each denominator event (discharges), the follow-up visit must occur after the applicable discharge. An outpatient visit on the date of discharge should be included in the measure.</p>
30-day follow-up	An outpatient follow-up encounter with a mental health practitioner up to 30 days after hospital discharge. To identify outpatient follow-up encounters, use the CPT codes or the UB-92 revenue codes in Table FUH-B.
7-day follow-up	An outpatient follow-up encounter with a mental health practitioner up to 7 days after hospital discharge. To identify outpatient follow-up encounters, use the CPT codes or the UB-92 revenue codes in Table FUH-B.

III. Hybrid Specification

None.

Table FUH-B: Codes to Identify Outpatient Mental Health Encounters or Intermediate Treatment

Description	CPT	HCPCS	UB-92 Revenue *
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Outpatient or intermediate care	90801, 90802, 90804-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90871, 90875-90876, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99510	G0155, G0176, G0177, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S9480, S9484, S9485	0513, 0900, 0901, 0905-0907, 0909-0916, 0961
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*The MCO does not need to determine practitioner type for follow-up visits identified through UB-92 Revenue codes.

An MCHP that submits HEDIS data to NCQA must provide the following data elements:

Table 7 – Data Elements for Follow-Up After Hospitalization for Mental Illness (FUH)

	Administrative
Measurement year	✓
Data collection methodology (administrative)	✓
Eligible population	✓
Numerator events by administrative data	<i>Each of the 2 rates</i>
Reported rate	<i>Each of the 2 rates</i>
Lower 95% confidence interval	<i>Each of the 2 rates</i>
Upper 95% confidence interval	<i>Each of the 2 rates</i>

HEDIS 2007 ANNUAL DENTAL VISIT (ADV)

The following is the definition of the Annual Dental Visit measure, an Effectiveness of Care measure, and the specific parameters as defined by the NCQA.

The percentage of enrolled members 2–21 years of age who had at least one dental visit during the measurement year. This measure applies only if dental care is a covered benefit in the MCO's Medicaid contract.

Table 8 - HEDIS 2007 Technical Specifications for Annual Dental Visit (ADV)

I. Eligible Population	
Product line	Medicaid.
Ages	2–21 years as of December 31 of the measurement year. The measure is reported for each of the following age stratifications and as a combined rate. <ul style="list-style-type: none"> • 2–3-years • 4–6-years • 7–10-years • 11–14-years • 15–18-years • 19–21-years • Total
Continuous enrollment	The measurement year.
Allowable gap	No more than 1 gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Dental.
Event/diagnosis	None.
II. Administrative Specification	
Denominator	The eligible population for each age group and the combined total.
Numerator	One or more dental visits with a dental practitioner during the measurement year. A member had a dental visit if a submitted claim/encounter contains any of the codes in Table ADV-A.
III. Hybrid Specification	
	None.

Table ADV-A: Codes to Identify Annual Dental Visits

CPT	HCPSC/CDT-3	ICD-9-CM Procedure
70300, 70310, 70320, 70350, 70355	D0120-D0999, D1110-D2999, D3110-D3999, D4210-D4999, D5110-D5899, D6010-D6205, D7111-D7999, D8010-D8999, D9110-D9999	23, 24, 87.11, 87.12, 89.31, 93.55, 96.54, 97.22, 97.33-97.35, 99.97

Note: Current Dental Terminology (CDT) is the equivalent dental version of the CPT physician procedural coding system.

An MCHP that submits HEDIS data to NCQA must provide the following data elements:

Table 9 - Data Elements for Annual Dental Visits

	Administrative
Measurement year	✓
Data collection methodology (administrative)	✓
Eligible population	<i>For each age stratification and total</i>
Numerator events by administrative data	<i>For each age stratification and total</i>
Reported rate	<i>For each age stratification and total</i>
Lower 95% confidence interval	<i>For each age stratification and total</i>
Upper 95% confidence interval	<i>For each age stratification and total</i>

METHODS OF CALCULATING PERFORMANCE MEASURES

The HEDIS technical specifications provide for two possible methods of calculating performance measures: 1) the Administrative Method and 2) the Hybrid Method. Of the measures selected for this review, only the Adolescent Well-Care Visits measure permits the use of either the Administrative or Hybrid methods; Annual Dental Visit and Follow-Up After Hospitalization for Mental Illness must each be calculated using the Administrative Method.

The Administrative Method involves examining claims and other databases (administrative data) to calculate the number of members in the entire eligible population who received a particular service (e.g., well-child visits, dental visits or follow-up visits). The eligible population is defined by the HEDIS technical specifications. Those cases in which administrative data show that the member received the service(s) examined are considered “hits”, or “administrative hits.” The HEDIS technical specifications provide acceptable administrative codes for identifying an administrative hit.

For the Hybrid Method, administrative data are examined to select members eligible for the measure. From these eligible members, a random sample is taken from the appropriate measurement year. Members in the sample are identified who received the service(s) as evidenced by a claim submission or through external sources of administrative data (e.g., State Public Health Agency Vital Statistics or Immunization Registry databases). Those cases in which an administrative hit cannot be determined are identified for further medical record review.

Documentation of all or some of the services in the medical record alone or in combination with administrative data is considered a “hybrid hit.”

Administrative hits and hybrid hits are then summed to form the numerator of the rate of members receiving the service of interest (e.g., appropriate doctor’s visit). The denominator of the rate is represented by the eligible population (administrative method) or those sampled from the eligible population (hybrid method). A simple formula of dividing the numerator by the denominator produces the percentage (also called a “rate”) reported to the SMA and the SPHA.

Additional guidance is provided in the HEDIS 2007 Technical Specifications: Volume 2¹¹ for appropriate handling of situations involving oversampling, replacement, and treatment of contraindications for services.

¹¹ National Committee for Quality Assurance. HEDIS 2007, Volume 2: Technical Specifications. Washington, D.C.: NCQA.

TIME FRAME

The proper time frame for selection of the eligible population for each measure is provided in the HEDIS technical specifications. For the measures selected, the “measurement year” referred to calendar year (CY) 2006. All events of interest (e.g. follow-up visits) must also have occurred during CY2006.

PROCEDURES FOR DATA COLLECTION

The HEDIS 2007 technical specifications for each measure validated were reviewed by the EQRO Project Director and the EQRO Research Analyst. Extensive training in data management and programming for healthcare quality indices, clinical training, research methods, and statistical analysis expertise were well represented among the personnel involved in adapting and implementing the Validating of Performance Measures Protocol to conform to the HEDIS, SMA, and SPHA requirements while maintaining consistency with the Validating Performance Measures Protocol. The following sections describe the procedures for each activity in the Validating Performance Measures Protocol as they were implemented for the three HEDIS 2007 measures validated.

Pre-On-Site Activity One: Reviewer Worksheets

Reviewer Worksheets were developed for the purpose of conducting activities and recording observations and comments for follow-up at the site visits. These worksheets were reviewed and revised to update each specific item with the HEDIS 2007 technical specifications. Project personnel met throughout November and December 2007 to review available source documents and develop the Reviewer Worksheets for conducting pre-on-site, on-site, and post-on-site activities as described below. These reviews formed the basis for completing the CMS Protocol Attachments (V, VII, X, XII, XIII, and XV) of the Validating Performance Measures Protocol for each measure and MO HealthNet Managed Care health plan. Source documents used to develop the methods for review and complete the Attachments included the following:

- HEDIS 2007 Data Submission Tool (DST)

- HEDIS 2007 Baseline Assessment Tool (BAT)
- HEDIS 2007 Audit Report
- HEDIS 2007 SPHA Reports

Pre-On-Site Activity Two: Preparation of MO HealthNet MCOs

Orientation teleconferences with each MO HealthNet MCHP were conducted from December 3, 2007 through December 14, 2007 by the EQRO. The purpose of this orientation conference was to provide education about the Validating Performance Measures protocol and the EQRO's submission requirements. All written materials, letters and instructions used in the orientation were reviewed and approved by the SMA in advance. Prior to the teleconference calls, the MO HealthNet Managed Care health plans were provided information on the technical objectives, methods, procedures, data sources, and contact information for EQRO personnel. The health plans were requested to have in attendance the person(s) responsible for the calculation of the HEDIS 2007 performance measures validated. Teleconference meetings were led by the EQRO Project Director, with key project personnel and a representative from the SMA in attendance. Provided via the teleconferences was technical assistance focused on describing the Validating Performance Measures Protocol; identification of the three measures selected for validation; the purpose, activities and objectives of the EQRO; and definitions of the information and data needed for the EQRO to validate the performance measures. All MO HealthNet Managed Care health plan questions about the process were answered at this time and identified for further follow-up by the EQRO if necessary. In addition to these teleconference calls, presentations and individual communications with personnel at MO HealthNet Managed Care health plans responsible for HEDIS 2007 performance measure calculation were conducted between December 2007 and June 2008, with follow-up telephone calls and written communications continuing as necessary through July 2008.

On December 20, 2007, formal written requests for data and information for the validation of performance measures were submitted to the MO HealthNet Managed Care health plans by the EQRO. This information was to be returned to

the EQRO by January 28, 2008 (see Appendix 3). A separate written request was sent to the health plans on February 13, 2008 requesting medical records be submitted to the EQRO for a sample of cases. These records were to be submitted by the providers to the EQRO by March 24, 2008. Detailed letters and instructions were mailed to QI/UM Coordinators and MO HealthNet Managed Care health plan Administrators explaining the type of information, purpose, and format of submissions. EQRO personnel were available and responded to electronic mail and telephone inquiries and any requested clarifications throughout the evaluation process. The following are the data and documents requested from MO HealthNet Managed Care health plans for the Validating Performance Measures Protocol:

- HEDIS 2007 Data Submission Tool for all three measures for the MO HealthNet Managed Care Population only.
- 2007 HEDIS Audit Report.
- Baseline Assessment Tool for HEDIS 2007.
- List of cases for denominator with all HEDIS 2007 data elements specified in the measures.
- List of cases for numerators with all HEDIS 2007 data elements specified in the measures, including fields for claims data and all other administrative data used.
- All worksheets, memos, minutes, documentation, policies and communications within the health plan and with HEDIS auditors regarding the calculation of the selected measures.
- List of cases for which medical records were reviewed, with all HEDIS 2007 data elements specified in the measures.
- Sample medical record tools used for hybrid methods for the three HEDIS 2007 measures for the MO HealthNet Managed Care population; and instructions for reviewers.
- Policies, procedures, data and information used to produce numerators and denominators.
- Policies, procedures, and data used to implement sampling (if sampling was used). At a minimum, this should include documentation to facilitate evaluation of:

- Statistical testing of results and any corrections or adjustments made after processing.
- Description of sampling techniques and documentation that assures the reviewer that samples used for baseline and repeat measurements of the performance measures were chosen using the same sampling frame and methodology.
- Documentation of calculation for changes in performance from previous periods (if comparisons were made), including tests of statistical significance.
- Policies and procedures for mapping non-standard codes, where applicable.
- Record and file formats and descriptions for entry, intermediate, and repository files.
- Electronic transmission procedures documentation. (This will apply if the health plan sends or receives data electronically from vendors performing the HEDIS abstractions, calculations or data entry)
- Descriptive documentation for data entry, transfer, and manipulation programs and processes.
- Samples of data from repository and transaction files to assess accuracy and completeness of the transfer process.
- Documentation of proper run controls and of staff review of report runs.
- Documentation of results of statistical tests and any corrections or adjustments to data along with justification for such changes.
- Documentation of sources of any supporting external data or prior years' data used in reporting.
- Procedures to identify, track, and link member enrollment by product line, product, geographic area, age, sex, member months, and member years.
- Procedures to track individual members through enrollment, disenrollment, and possible re-enrollment.
- Procedures used to link member months to member age.
- Documentation of "frozen" or archived files from which the samples were drawn, and if applicable, documentation of the health plan's process to re-draw a sample or obtain necessary replacements.

- Procedures to capture data that may reside outside the health plan's data sets (e.g. MOHSAIC).
- Policies, procedures, and materials that evidence proper training, supervision, and adequate tools for medical record abstraction tasks. (May include training material, checks of inter-rater reliability, etc.)

Pre-On-Site Activity Three: Assess the Integrity of the MCHP's Information System

The objective of this activity was to assess the integrity of the MO HealthNet Managed Care health plans' ability to link data from multiple sources. All relevant documentation submitted by the MO HealthNet Managed Care health plans was reviewed by EQRO personnel. The review protocols indicate that an Information Systems Capability Assessment (ISCA) be administered every other year. The 2006 review year contained a full ISCA analysis; therefore, a new ISCA was not conducted for the 2007 review. EQRO personnel also reviewed HEDIS 2007 Baseline Assessment Tool (BAT) submitted by each health plan. Detailed notes and follow-up questions were formulated for the site visit reviews.

On-Site Activity One: Assess Data Integration and Control

The objective of this activity was to assess the MO HealthNet Managed Care health plans' ability to link data from multiple sources and determine whether these processes ensure the accurate calculation of the measures. A series of interviews and in-depth reviews were conducted by the EQRO with MO HealthNet Managed Care health plan personnel (including both management and technical staff and 3rd party vendors when applicable). These site visit activities examined the development and production procedures of the HEDIS 2007 performance measures and the reporting processes, databases, software, and vendors used to generate these rates. This included reviewing data processing issues for generating the rates and determining the numerator and denominator counts. Other activities involved reviewing database processing systems, software, organizational reporting structures, and sampling methods. The following are the activities conducted at each health plan:

- Review results of run queries (on-site observation, screen-shots, test output)
- Examination of data fields for numerator & denominator calculation (examine field definitions and file content)
- Review of applications, data formats, flowcharts, edit checks and file layouts
- Review of source code, software certification reports
- Review HEDIS repository procedures, software manuals
- Test for code capture within system for measures (confirm principal & secondary codes, presence/absence of non-standard codes)
- Review of operating reports
- Review information system policies (data control, disaster recovery)
- Review vendor associations & contracts

The following are the interview questions developed for the site visits:

- What are the processes of data integration and control within information systems?
- What documentation processes are present for collection of data, steps taken and procedures to calculate the HEDIS measures?
- What processes are used to produce denominators?
- What processes are used to produce numerators?
- How is sampling done for calculation of rates produced by the hybrid method?
- How does the MCHP submit the requirement performance reports to the State?

From the site visit activities, interviews, and document reviews, Attachment V (Data Integration and Control Findings) of the CMS Protocol was completed for each MO HealthNet Managed Care health plan and performance measure validated.

On-Site Activity Two: Assess Documentation of Data and Processes Used to Calculate and Report Performance Measures

The objectives of this activity were to assess the documentation of data collection, assess the process of integrating data into a performance measure set, and examine procedures used to query the data set to identify numerators, denominators, generate a sample, and apply proper algorithms.

From the site visit activities, interviews, review of numerator and denominator files and document reviews, Attachment VII (Data and Processes Used to Calculate and Report Performance) of the CMS Protocol was completed for each MO HealthNet Managed Care health plan and measure validated. One limitation of this step was the inability of the health plans to provide documentation of processes used to calculate and report the performance measures due to the use of proprietary software or off-site vendor software and claims systems. However, all MO HealthNet Managed Care health plans were able to provide documentation and flow-charts

of these systems to illustrate the general methods employed by the software packages to calculate these measures.

On-Site Activity Three: Assess Processes Used to Produce the Denominators

The objectives of this activity were to: 1) to determine the extent to which all eligible members were included; 2) to evaluate programming logic and source codes relevant to each measure; and 3) to evaluate eligibility, enrollment, age, codes, and specifications related to each performance measure.

The content and quality of the data files submitted were reviewed to facilitate the evaluation of compliance with the HEDIS 2007 technical specifications. The MO HealthNet Managed Care health plans consistently submitted the requested level of data (e.g., all elements required by the measures or information on hybrid or administrative data). In order to produce meaningful results, the EQRO required that all the health plans submit data in the format requested. Although corrected data had to be requested, all MO HealthNet Managed Care health plans did submit the data requested in the proper format prior to completion of the validation process.

From the site visit activities, interviews, review of numerator and denominator files and document reviews, Attachment X (Denominator Validation Findings) of the CMS Protocol was completed for each MO HealthNet Managed Care health plan and performance measure validated.

On-Site Activity Four: Assess Processes Used to Produce the Numerators

The objectives of this activity were to: 1) evaluate the MO HealthNet Managed Care health plans' ability to accurately identify medical events (e.g., appropriate doctor's visits); 2) evaluate the health plans' ability to identify events from other sources (e.g., medical records, State Public Immunization Registry); 3) assess the use of codes for medical events; 4) evaluate procedures for non-duplication of event counting; 5) examine time parameters; 6) review the use of non-standard codes and maps; 7) identify medical record review procedures (Hybrid Method); and 8) review the process of integrating administrative and medical record data.

Validation of the numerator data for all three measures was conducted using the parameters specified in the HEDIS 2007 Technical Specifications; these parameters applied to dates of service(s), diagnosis codes, and procedure codes appropriate to the measure in question. The Annual Dental Visit measure, for example, requires that all dates of service occurred between January 1, 2006 and December 31, 2006. Visits outside this valid date range were not considered. Similar validation was conducted for all three measures reviewed. This numerator validation was conducted on either all numerator cases (Administrative Method) or on a sample of cases (Hybrid Method).

Additional validation for measures calculated using the Hybrid Method was also conducted. The Protocol requires the EQRO to sample up to 30 records from the medical records reported by the MO HealthNet Managed Care health plan as meeting the numerator criteria (hybrid hits). In the event that the health plan reported fewer than 30 numerator events from medical records, the EQRO requested all medical records that were reported by the health plan as meeting the numerator criteria. This approach did not apply to the Follow-Up After Hospitalization for Mental Illness or Annual Dental Visit measures, as the Administrative Method of calculation is required for these measures by HEDIS technical specifications.

Initial requests for documents and data were made on December 20, 2007, with submissions due to the EQRO by January 28, 2008. The EQRO required the MO HealthNet Managed Care health plans to request medical records from the providers. On February 13, 2008, the MO HealthNet Managed Care health plans were given a list of medical records to request, a letter from DMS explaining the purpose of the request, and the information necessary for the providers to send the medical records directly to the EQRO. The submission deadline for medical records was March 24, 2008. The record receipt rate was excellent; of the 60 records contained in the sample, all 60 were received by the EQRO for review.

The review of medical records was administered by Reliable HealthCare Services, Inc. (RHS), a temporary healthcare services provider located in Kansas City, Missouri and a Business Associate of Behavioral Health Concepts, Inc., (the EQRO). RHS is a State of Missouri certified Minority-Owned Business Enterprise (MBE) operated by two registered nurses. RHS possesses expertise in recruiting nursing and professional health care staff for clinical, administrative, and HEDIS medical record review services. The review of medical records was conducted by RNs with over 20 years of clinical experience and who were currently licensed and practicing in the State of Missouri. Two RNs participated in the training and medical record review process and both had at least five years of experience conducting medical record reviews for HEDIS measures.

A medical record abstraction tool for the Adolescent Well-Care Visits measure was developed by the EQRO Project Director and revised in consultation with a nurse consultant, the EQRO Research Analyst, and with the input from the nurse reviewers. The 2007 HEDIS technical specifications and the Validating Performance Measures Protocol criteria were used to develop the medical record review tools and data analysis plan. A medical record review manual and documentation of ongoing reviewer questions and resolutions were developed for the review. A half day of training was conducted by the EQRO Project Director and staff on March 31, 2008 using sample medical record tools and reviewing all responses with feedback and discussion. The reviewer training and training manual covered content areas such as Health Insurance Portability and Accountability Act (HIPAA), confidentiality, conflict of interest, review tools, and project background. Teleconference meetings between the nurses, coders, and EQRO Project Director were conducted as needed to resolve questions and coding discrepancies throughout the duration of the medical record review process.

A data entry format with validation parameters was developed for accurate medical record review data entry. A data entry manual and training were provided to the data entry person at RHS, Inc. Data was reviewed weekly for accuracy and completeness, with feedback and corrections made to the data entry person. The

final databases were reviewed for validity, verified, and corrected prior to performing analyses. All data analyses were reviewed and analyzed by the EQRO Research Analyst and reviewed, approved and finalized by the EQRO Project Director. CMS Protocol Attachments XII (Impact of Medical Record Findings) and XIII (Numerator Validation Findings) were completed based on the medical record review of documents and site visit interviews.

On-Site Activity Five: Assess Sampling Process (Hybrid Method)

The objective of this activity was to assess the representativeness of the sample of care provided.

- Review HEDIS Baseline Assessment Tool (BAT)
- Review Data Submission Tool (DST)
- Review numerator and denominator files
- Conduct medical record review for measures calculated using hybrid methodology
- Determine the extent to which the record extract files are consistent with the data found in the medical records
- Review of medical record abstraction tools and instructions
- Conduct on-site interviews, activities, and review of additional documentation

For those health plans that calculated the Adolescent Well-Care Visits measure via hybrid methodology, a sample of medical records (up to 30) was conducted to validate the presence of an appropriate well-child visit that contributed to the numerator.

From the review of documents and site visits, CMS Protocol Attachment XV (Sampling Validation Findings) was completed for those MO HealthNet Managed Care health plans that elected the Hybrid Method for the HEDIS 2007 Adolescent Well-Care Visits measure.

On-Site Activity Six: Assess Submission of Required Performance Measures to State

The objective of this activity was to assure proper submission of findings to the SMA and SPHA.

The DST was obtained from the SPHA to determine the submission of the performance measures validated. Conversations with the SPHA representative responsible for compiling the measures for all MO HealthNet Managed Care health plans in the State occurred with the EQRO Project Director to clarify questions, obtain data, and follow-up on health plan submission status.

Post- On-Site Activity One: Determine Preliminary Validation Findings for each Measure

Calculation of Bias

The CMS Validating Performance Measures Protocol specifies the method for calculating bias based on medical record review for the Hybrid Method. In addition to examining bias based on the medical record review and the Hybrid Method, the EQRO calculated bias related to the inappropriate inclusion of cases with administrative data that fell outside the parameters described in the HEDIS 2007 Technical Specifications. For measures calculated using the Administrative Method, the EQRO examined the numerators and denominators for correct date ranges for dates of birth and dates of service as well as correct enrollment periods and codes used to identify the medical events. This was conducted as described above under on-site activities three and four. The estimated bias in the calculation of the HEDIS 2007 measures for the Hybrid Method was calculated using the following procedures, methods and formulas, consistent with the Validating Performance Measures Protocol. Specific analytic procedures are described in the following section.

Analysis

Once the medical record review was complete, all administrative data provided by the MO HealthNet Managed Care health plans in their data file submissions for the HEDIS 2007 Adolescent Well-Care Visits measure were combined with the medical record review data collected by the EQRO. This allowed for calculation of the final rate. In order for each event of a well-care visit to be met, there had to be documented evidence of an appropriate well-care visit code as defined in the HEDIS 2007 Technical Specifications; sick visits or emergency room codes were not included. Only one well-care visit in the measurement year was required for a member to be considered a positive “hit”. Multiple well-care visits for one member within the measurement year were excluded; each member was only counted once.

For the calculation of bias based on medical record review for the MO HealthNet Managed Care health plans using the Hybrid Method for the HEDIS 2007 Adolescent Well-Care Visits measure, several steps were taken. First, the number of hits based on the medical record review was reported (Medical Records Validated by EQRO). Second, the Accuracy (number of Medical Records able to be validated by EQRO/total number of Medical Records requested by the EQRO for audit) and Error Rates (100% - Accuracy Rate) were determined. Third, a weight for each Medical Record was calculated (100%/denominator reported by the health plan) as specified by the Protocol. The number of False Positive Records was calculated (Error Rate * numerator hits from Medical Records reported by the health plan). This represents the number of records that were not able to be validated by the EQRO. The Estimated Bias from Medical Records was calculated (False Positive Rate * Weight of Each Medical Record).

To calculate the Total Estimated Bias in the calculation of the performance measures, the Administrative Hits Validated by the EQRO (through the previously described file validation process) and the Medical Record Hits Validated by the EQRO (as described above) were summed and divided by the total Denominator reported by the MCHP on the DST to determine the Rate Validated by the EQRO.

The difference between the Rate Validated by the EQRO and the Rate Reported by the MO HealthNet Managed Care health plan to the SMA and SPHA was the Total Estimated Bias. A positive number reflects an overestimation of the rate by the health plan, while a negative number reflects an underestimation.

Once the EQRO concluded its on-site activities, the validation activity findings for each performance measure were aggregated. This involved the review and analysis of findings and Attachments produced for each performance measure selected for validation and for the health plan's Information System as a result of pre-on-site and on-site activities. The EQRO Project Director reviewed and finalized all ratings and completed the Final Performance Measure Validation Worksheets for all measures validated for each of the MO HealthNet Managed Care health plans. Ratings for each of the Worksheet items (0 = Not Met; 1 = Partially Met; 2 = Met) were summed for each worksheet and divided by the number of applicable items to form a rate for comparison to other MO HealthNet Managed Care health plans. The worksheets for each measure were examined by the EQRO Project Director to complete the Final Audit Rating.

Below is a summary of the final audit rating definitions specified in the Protocol. Any measures not reported were considered "Not Valid." A Total Estimated Bias outside the 95% upper or lower confidence limits of the measures as reported by the MO HealthNet Managed Care health plan on the DST was considered "Not Valid".

Fully Compliant:	Measure was fully compliant with State (SMA and SPHA) specifications.
Substantially Compliant:	Measure was substantially compliant with State (SMA and SPHA) specifications and had only minor deviations that did not significantly bias the reported rate.
Not Valid:	<p>Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which the data provided to the EQRO could not be independently validated.</p> <p>'Significantly Biased' was defined by the EQRO as being outside the 95% confidence interval of the rate reported by the MO HealthNet Managed Care health plan on the HEDIS 2007 Data Submission Tool.</p>

3.4 Findings

MO HealthNet Managed Care health plans conduct the calculation of performance measures in collaboration with a variety of vendors and use a number of different management information systems to extract data for the calculation of measures. They are also required to undergo annual audits by NCQA-certified auditing firms that provide MO HealthNet Managed Care health plans with recommendations for reporting or not reporting findings of specific measures to the NCQA. Regardless of the NCQA audit rating or rotation, the health plans are required to report the performance measures validated to the SMA and SPHA. Table 10 summarizes the names of HEDIS-certified software used, medical record vendors, and HEDIS auditors for each of the MO HealthNet Managed Care health plans.

Table 10 - HEDIS 2007 Software, Vendors, and Auditors for the HEDIS 2007 Measures

MO HealthNet MCHP	Name of Software	Name of Medical Record Vendor	Name of HEDIS 2007 Auditor
Blue-Advantage Plus of Kansas City	Software from ViPs, Inc. MedMeasures*	QMark/HEDISHelp	Ernst & Young, LLP
Children's Mercy Family Health Partners	Software from ViPs, Inc. MedMeasures*	Children's Mercy Family Health Partners	Healthcare Data.com, LLC
Harmony Health Plan	CareEnhance Resource Management Software (CRMS)*	UNIVAL	Healthcare Data.com, LLC
HealthCare USA	Quality Spectrum* HEDIS repository by Catalyst Technologies	Not Applicable. Did not use Hybrid Method.	Healthcare Data.com, LLC
Mercy CarePlus	Amisys (Novasys) Quality Spectrum* HEDIS repository by Catalyst Technologies	QMark/HEDISHelp	Healthcare Research Associates
Missouri Care		Missouri Care	Thomson MedStat

Note: * NCQA-certified

Table 11 shows the method of calculation used by each MO HealthNet Managed Care health plan. This information was taken from the MO HealthNet Managed Care health plans' self-report to the EQRO.

Table 11 - Summary of Method of Calculation Reported and Validated by MO HealthNet Health Plans

MO HealthNet MCHP	Adolescent Well-Care Visits	Annual Dental Visit	Follow-Up After Hospitalization for Mental Illness
Blue-Advantage Plus of Kansas City	Administrative	Administrative	Administrative
Children's Mercy Family Health Partners	Hybrid	Administrative	Administrative
Harmony Health Plan	N/A	N/A	N/A
HealthCare USA	Administrative	Administrative	Administrative
Mercy CarePlus	Administrative	Administrative	Administrative
Missouri Care	Hybrid	Administrative	Administrative

The validation of each of the performance measures is discussed in the following sections with the findings from each validation activity described. Subsequent sections summarize the status of submission of the measures validated to the SMA and SPHA, the Final Audit Ratings, and conclusions.

HEDIS 2007 ANNUAL DENTAL VISIT

Data Integration and Control

The objective of this activity was to assess the MO HealthNet Managed Care health plans' ability to link data from multiple sources. It is based on the integrity of the management information systems and the ability to ensure accuracy of the measures. For the HEDIS 2007 Annual Dental Visit measure, the sources of data included enrollment, eligibility, and claim files. Table 12 summarizes the findings of Attachment V (Data Integration and Control Findings) of the CMS Protocol. The rate of items that were met was calculated across MO HealthNet Managed Care health plans and from the number of applicable items for each health plan. Of all the MO

HealthNet Managed Care health plans that calculated the measure, 100% Met all criteria for every audit element. As such, each health plan Met 100% of the criteria for data integration and control.

Table 12 - Data Integration and Control Findings, HEDIS 2007 Annual Dental Visit Measure

Item	Audit Elements	MO HealthNet MCHP					All MO HealthNet MCHPs				
		BA+	CMFHP	HCUSA	MCP	MOCare	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
5.1	MCHP/PIHP processes accurately and completely transfer data from the transaction files (e.g., membership, provider, encounter/claims) into the repository used to keep the data until the calculations of the performance measures have been completed and validated.	2	2	2	2	2	5	0	0	5	100.0%
5.2	Samples of data from repository are complete and accurate.	2	2	2	2	2	5	0	0	5	100.0%
5.3	MCHP's/PIHP's processes to consolidate diversified files, and to extract required information from the performance measure repository are appropriate.	2	2	2	2	2	5	0	0	5	100.0%
5.4	Actual results of file consolidations or extracts were consistent with those which should have resulted according to documented algorithms or specifications.	2	2	2	2	2	5	0	0	5	100.0%
5.5	Procedures for coordinating the activities of multiple subcontractors ensure the accurate, timely, and complete integration of data into the performance measure database.	2	2	2	2	2	5	0	0	5	100.0%
5.6	Computer program reports or documentation reflect vendor coordination activities, and no data necessary to performance measure reporting are lost or inappropriately modified during transfer.	2	2	2	2	2	5	0	0	5	100.0%
5.7	The repository's design, program flow charts, and source codes enable analyses and reports.	2	2	2	2	2	5	0	0	5	100.0%
5.8	Proper linkage mechanisms have been employed to join data from all necessary sources (e.g., identifying a member with a given disease/condition).	2	2	2	2	2	5	0	0	5	100.0%
5.9	Examine and assess the adequacy of the documentation governing the production process, including MCHP/PIHP production activity logs, and MCHP/PIHP staff review of report runs.	2	2	2	2	2	5	0	0	5	100.0%
5.10	Prescribed data cutoff dates were followed.	2	2	2	2	2	5	0	0	5	100.0%
5.11	The MCHP/PIHP has retained copies of files or databases used for performance measure reporting, in the event that results need to be reproduced.	2	2	2	2	2	5	0	0	5	100.0%
5.12	Review documentation standards to determine the extent to which the reporting software program is properly documented with respect to every aspect of the performance measurement reporting repository, including building, maintaining, managing, testing, and report production.	2	2	2	2	2	5	0	0	5	100.0%
5.13	Review the MCHP's/PIHP's processes and documentation to determine the extent to which they comply with the MCHP/PIHP standards associated with reporting program specifications, code review, and testing.	2	2	2	2	2	5	0	0	5	100.0%
	Number Met	13	13	13	13	13	65	0	0	65	100.0%
	Number Partially Met	0	0	0	0	0					
	Number Not Met	0	0	0	0	0					
	Number Applicable	13	13	13	13	13					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met ; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.

Source: BHC, Inc. 2007 External Quality Review Performance Measure Validation.



Documentation of Data and Processes

The objectives of this activity were to assess the documentation of data collection; the process of integrating data into a performance measure set; the procedures used to query the data set for sampling numerators and denominators; and the ability to apply proper algorithms. The findings of Attachment VI (Data and Processes Used to Calculate and Report Performance Measures) of the CMS Protocol are summarized in Table 13. Items 7.2, 7.3, 7.5, 7.7, 7.9, and 7.10 did not apply to this measure. All MO HealthNet Managed Care health plans (100.0%) Met the criteria for applying appropriate data and processes for the calculation of the HEDIS 2007 Annual Dental Visit measure.

Table 13 - Data and Processes Used to Calculate and Report Performance Measures, HEDIS 2007 Annual Dental Visit

Item	Audit Elements	MO HealthNet MCHP					All MO HealthNet MCHPs				
		BA+	CMFHP	HCUSA	MCP	MOCare	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
7.1	Data file and field definitions used for each measure.	2	2	2	2	2	5	0	0	5	100.0%
7.2	Maps to standard coding if not used in original data collection.	NA	NA	NA	NA	NA	0	0	0	0	NA
7.3	Statistical testing of results and any corrections or adjustments made after processing.	NA	NA	NA	NA	NA	0	0	0	0	NA
7.4	All data sources, including external data (whether from a vendor, public registry, or other outside source), and any prior years' data (if applicable).	2	2	2	2	2	5	0	0	5	100.0%
7.5	Detailed medical record review methods and practices, including the qualifications of medical record review supervisor and staff; reviewer training materials; audit tools used, including completed copies of each record-level reviewer determination; all case-level critical performance measure data elements used to determine a positive or negative event or exclude a case from same; and inter-rater reliability testing procedures and results.	NA	NA	NA	NA	NA	0	0	0	0	NA
7.6	Detailed computer queries, programming logic, or source code used to identify the population or sample for the denominator and/or numerator.	2	2	2	2	2	5	0	0	5	100.0%
7.7	If sampling used, description of sampling techniques, and documentation that assures the reviewer that samples used for baseline and repeat measurements of the performance measures were chosen using the same sampling frame and methodology.	NA	NA	NA	NA	NA	0	0	0	0	NA
7.8	Documentation of calculation for changes in performance from previous periods (if applicable), including statistical tests of significance.	2	2	2	2	2	5	0	0	5	100.0%
7.9	Data that are related from measure to measure are consistent (e.g., membership counts, provider totals, number of pregnancies and births).	NA	NA	NA	NA	NA	0	0	0	0	NA
7.10	Appropriate statistical functions are used to determine confidence intervals when sampling is used in the measure.	NA	NA	NA	NA	NA	0	0	0	0	NA
7.11	When determining improvement in performance between measurement periods, appropriate statistical methodology is applied to determine levels of significance of changes.	2	2	2	2	2	5	0	0	5	100.0%
	Number Met	5	5	5	5	5	25	0	0	25	100.0%
	Number Partially Met	0	0	0	0	0					
	Number Not Met	0	0	0	0	0					
	Number Applicable	5	5	5	5	5					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met ; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.

Source: BHC, Inc. 2007 External Quality Review Performance Measure Validation

Processes Used to Produce Denominators

The objective of this activity was to determine the extent to which all eligible members were included in the denominator, evaluate the programming and logic source codes, and evaluate the specifications for calculating each measure. Table 14 summarizes the findings of Attachment X (Denominator Validation Findings) of the CMS Protocol. Items 10.5 (Identification of gender of the member), 10.6 (Calculation of member months or years), and 10.10 (Systems for estimating populations when they are unable to accurately be counted) were not applicable to this measure. Of the five MO HealthNet Managed Care health plans reviewed, 100% Met the criteria for producing denominators according to specifications.

Table 14 - Denominator Validation Findings, HEDIS 2007 Annual Dental Visit

Item	Audit Elements	MO HealthNet MCHP					All MO HealthNet MCHPs				
		BA+	CMFHP	HCUSA	MCP	MOCare	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
10.1	All members who were eligible to receive the specified services were included in the initial population from which the final denominator was produced. This "at risk" population included both members who received the services, as well as those who did not. This same standard applies to provider groups or other relevant populations identified in the specifications of each performance measure.	2	2	2	2	2	5	0	0	5	100.0%
10.2	For each measure, programming logic or source code which identifies, tracks, and links member enrollment within and across product lines (e.g., Medicare and Medicaid), by age and sex, as well as through possible periods of enrollment and disenrollment, has been appropriately applied according to the specifications of each performance measure.	2	2	2	2	2	5	0	0	5	100.0%
10.3	Calculations of continuous enrollment criteria were correctly carried out and applied to each measure (if applicable).	2	2	2	2	2	5	0	0	5	100.0%
10.4	Proper mathematical operations were used to determine patient age or range.	2	2	2	2	2	5	0	0	5	100.0%
10.5	The MCHP/PIHP can identify the variable(s) that define the member's sex in every file or algorithm needed to calculate the performance measure denominator, and the MCHP/PIHP can explain what classification is carried out if neither of the required codes is present.*	NA	NA	NA	NA	NA	0	0	0	0	NA
10.6	The MCHP/PIHP has correctly calculated member months and member years, if applicable to the performance measure.*	NA	NA	NA	NA	NA	0	0	0	0	NA
10.7	The MCHP/PIHP has properly evaluated the completeness and accuracy of any codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and these codes have been appropriately identified and applied as specified in each performance measure.	2	2	2	2	2	5	0	0	5	100.0%
10.8	Any time parameters required by the specifications of the performance measure are followed (e.g., cut off dates for data collection, counting 30 calendar days after discharge from a hospital, etc.).	2	2	2	2	2	5	0	0	5	100.0%
10.9	members from a denominator were followed. For example, if a measure relates to receipt of a specific service, the denominator may need to be adjusted to reflect instances in which the patient refuses the service or the service is contraindicated.	2	2	2	2	2	5	0	0	5	100.0%
10.10	Systems or methods used by the MCHP/PIHP to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.*	NA	NA	NA	NA	NA	0	0	0	0	NA
	Number Met	7	7	7	7	7	35	0	0	35	100.0%
	Number Partially Met	0	0	0	0	0					
	Number Not Met	0	0	0	0	0					
	Number Applicable	7	7	7	7	7					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%					

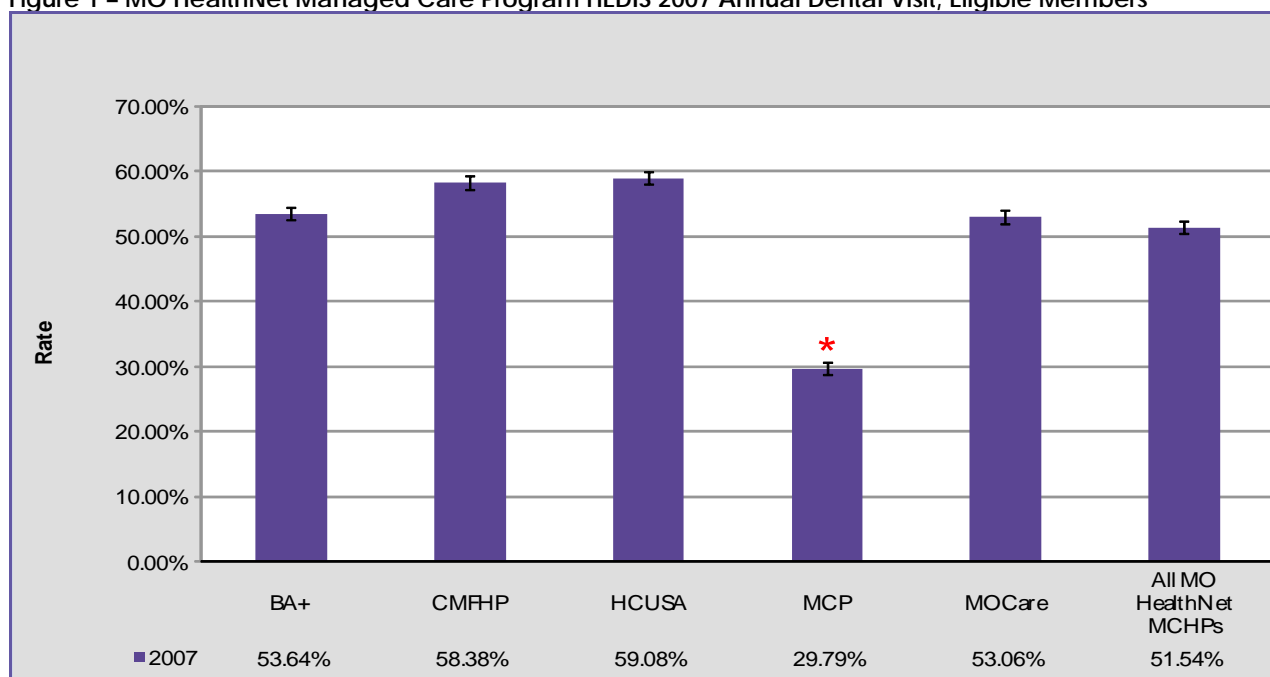
Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met ; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.

Source: BHC, Inc. 2007 External Quality Review Performance Measure Validation.



When determining the denominator, it was expected that all MO HealthNet Managed Care health plans would identify similar percentages of their total population as eligible for this measure. The identification of eligible members for the HEDIS 2007 Annual Dental Visit measure is dependent on the quality of the enrollment and eligibility files. The rate of eligible members (eligible population identified / total MO HealthNet enrollment) was calculated for all health plans and is illustrated in Figure 1. Two-tailed z-tests of each health plan were conducted comparing the health plans to the rate of eligible members for all MO HealthNet Managed Care health plans at the 95% level of confidence. The percentage of eligible members identified by Mercy CarePlus (29.79%) showed a statistically significant difference (e.g. statistically lower rate) when compared to the group average. This difference in rates may be due to the demographic characteristics of the member population, the completeness of claims data, or the processes of identifying eligible members.

Figure 1 – MO HealthNet Managed Care Program HEDIS 2007 Annual Dental Visit, Eligible Members



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance. Enrollment as of the last week in December 2006 (the measurement year) was used to calculate the rate.

Sources: MO HealthNet MCHP HEDIS 2007 Data Submission Tool (DST); Missouri Department of Social Services, Division of Medical Services, State MPRI Session Screens, enrollment figures for all Waivers, December 31, 2006.

Processes Used to Produce Numerators

The objectives of this activity were to evaluate the MO HealthNet Managed Care health plans' ability to accurately identify medical events, evaluate the ability to identify events from other sources, evaluate procedures for non-duplicate counting of multiple events, review time parameters and the use of non-standard code maps, and assess the processes and procedures for collecting and incorporating medical record review data. The Technical Specifications for the HEDIS 2007 Annual Dental Visit measure required the measure be calculated using the Administrative Method; the Hybrid Method procedures do not apply.

Table 15 shows the numerators, denominators, rates, and confidence intervals submitted by the MO HealthNet Managed Care health plans to the SPHA on the DST for the HEDIS 2007 Annual Dental Visit measure. The rate for all health plans was calculated by the EQRO; therefore, no confidence interval is reported for the statewide rate. HealthCare USA reported rates for each of the three regions (Eastern, Central, and Western) separately to the SPHA; as it is the task of the EQRO to compare MCO to MCO, these numbers have been combined to show an overall MCO rate. Therefore, there is no confidence interval to report, because the MCO reported confidence intervals for each region and not as a plan on the DST.

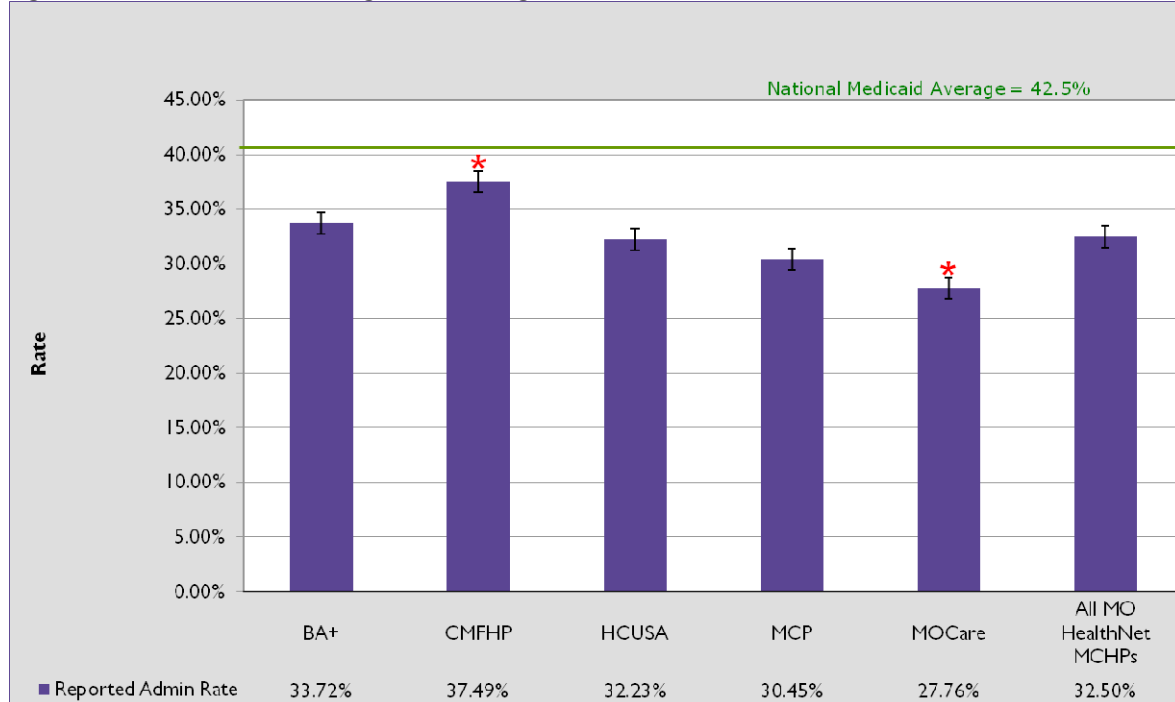
Just as in 2005, the last EQR year when this measure was audited, all MO HealthNet Managed Care health plans reported individual rates lower than the National Medicaid Average (42.5%) and the combined rate for all health plans was lower than that average as well. However, the rate for all MO HealthNet Managed Care health plans was 32.50% in 2007 and only 29.76% in 2005, thereby showing an increase in access to dental visits within the MO HealthNet Managed Care population. The 2007 health plan rates ranged from 27.76% (Missouri Care) to 37.49% (Children's Mercy Family Health Partners) (see Table 15 and Figure 2). Missouri Care reported a significantly lower rate than the average combined rate for all MO HealthNet Managed Care health plans; the rate reported by Children's Mercy Family Health Partners was significantly higher than the average.

Table 15 - Data Submission and Final Validation for HEDIS 2007 Annual Dental Visit (combined rate)

MO HealthNet Health Plan	Eligible Population	Number Administrative Hits Reported by MCHP (DST)	Rate Reported by MCHP (DST)	LCL - UCL (DST)	Administrative Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Blue Advantage Plus	14,138	4,768	33.72%	32.94-34.51%	4,761	33.68%	0.05%
Childrens Mercy Family Health Partners	23,806	8,926	37.49%	36.88-38.11%	8,913	37.44%	0.05%
HealthCare USA	88,406	28,493	32.23%		28,447	32.18%	0.05%
Mercy CarePlus	20,617	6,278	30.45%	29.82-31.08%	6,273	30.43%	0.02%
Missouri Care	14,945	4,149	27.76%	27.04-28.48%	4,137	27.68%	0.08%
All MO HealthNet MCHPs	161,912	52,614	32.50%		52,531	32.44%	0.05%

Note: DST = Data Submission Tool; NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); LCL = 95% Lower Confidence Limit; UCL = 95% Upper Confidence Limit. Rate Validated by EQRO = Administrative Hits Validated by EQRO / Eligible Population. Estimated Bias = Rate Reported by MCHP (DST) - Rate Validated by EQRO. Positive bias indicates an overestimate.

Source: MO HealthNet Managed Care Health Plans' HEDIS 2007 Data Submission Tools (DST).

Figure 2 - MO HealthNet Managed Care Program HEDIS 2007 Annual Dental Visit, Administrative Rates

Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance.

Sources: MO HealthNet MCHP HEDIS 2007 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

Table 16 shows the validation of numerators based on the review of numerator extract files and the medical record review. Item 13.2 was not applicable to this measure, as the services reported could not easily be obtained outside the health plan. Item 13.6 also did not apply, as none of the MO HealthNet Managed Care health plans used non-standard codes to determine the numerators. Items 13.8 through 13.13 relate to the Hybrid Method and were not applicable for the Annual Dental Visit measure. Across all MO HealthNet Managed Care health plans, 100% of the criteria for calculating the numerator were met.

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Table 16 - Numerator Validation Findings, HEDIS 2007 Annual Dental Visit Measure

Item	Audit Elements	MO HealthNet MCHP					All MO HealthNet MCHPs				
		BA+	CMFHP	HCUSA	MCP	MOCare	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
13.1	The MCHP/PIHP has used the appropriate data, including linked data from separate data sets, to identify the entire at-risk population.	2	2	2	2	2	5	0	0	5	100.0%
13.2	The MCHP/PIHP has in place and utilizes procedures to capture data for those performance indicators that could be easily under-reported due to the availability of services outside the MCHP/PIHP.	NA	NA	NA	NA	NA	0	0	0	0	NA
13.3	The MCHP's/PIHP's use of codes used to identify medical events are complete, accurate, and specific in correctly describing what has transpired and when.	2	2	2	2	2	5	0	0	5	100.0%
13.4	when classifying members for inclusion or exclusion in the numerator.	2	2	2	2	2	5	0	0	5	100.0%
13.5	The MCHP/PIHP has avoided or eliminated all double-counted members or numerator events.	2	2	2	2	2	5	0	0	5	100.0%
13.6	Any non-standard codes used in determining the numerator have been mapped to a standard coding scheme in a manner that is consistent, complete, and reproducible as evidenced by a review of the programming logic or a demonstration of the program.	NA	NA	NA	NA	NA	0	0	0	0	NA
13.7	Any time parameters required by the specifications of the performance measure are adhered to (i.e., that the measured event occurred during the time period specified or defined in the performance measure).	2	2	2	2	2	5	0	0	5	100.0%
13.8	Medical record reviews and abstractions have been carried out in a manner that facilitates the collection of complete, accurate, and valid data.	NA	NA	NA	NA	NA	0	0	0	0	NA
13.9	Record review staff have been properly trained and supervised for the task.	NA	NA	NA	NA	NA	0	0	0	0	NA
13.10	Record abstraction tools require the appropriate notation that the measured event occurred.	NA	NA	NA	NA	NA	0	0	0	0	NA
13.11	Record abstraction tools require notation of the results or findings of the measured event (if applicable).	NA	NA	NA	NA	NA	0	0	0	0	NA
13.12	Data included in the record extract files are consistent with data found in the medical records as evidenced by a review of a sample of medical record for applicable performance measures. (From Medical Record Review Validation Tools-Table 5, ATTACHMENT XII)	NA	NA	NA	NA	NA	0	0	0	0	NA
13.13	The process of integrating administrative data and medical record data for the purpose of determining the numerator is consistent and valid.	NA	NA	NA	NA	NA	0	0	0	0	NA
	Number Met	5	5	5	5	5	25	0	0	25	100.0%
	Number Partially Met	0	0	0	0	0					
	Number Not Met	0	0	0	0	0					
	Number Applicable	5	5	5	5	5					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met ; 0 = Not Met, validated through HEDIS

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software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. *

Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.

Source: BHC, Inc. 2007 External Quality Review Performance Measure Validation.



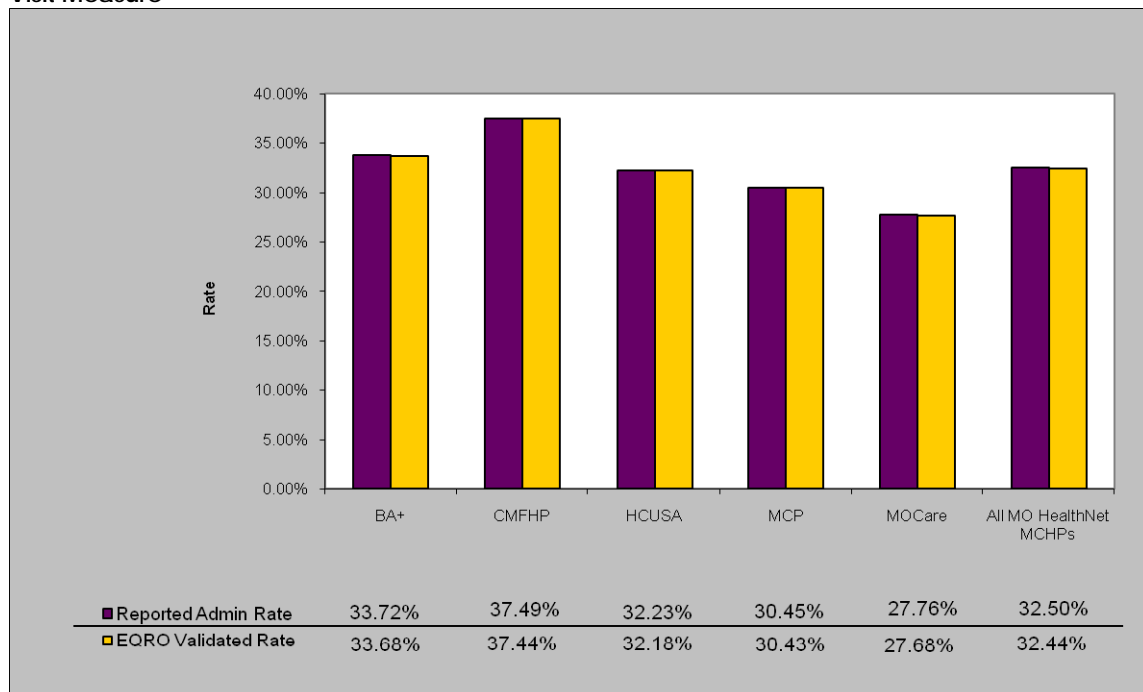
Submission of Measures to the State

Reports from the SPHA were obtained regarding the submission of the HEDIS 2007 Annual Dental Visit measure. All five MO HealthNet Managed Care health plans calculated and submitted the measure to the SPHA and SMA. All health plans in the State of Missouri are required to calculate and report the measure to the SPHA, and MO HealthNet Managed Care health plans are required to report the measure to the SMA.

Final Validation Findings

Table 15 shows the final data validation findings and the total estimated bias calculation based on the validation and review of the MO HealthNet Managed Care health plans' extract files for calculating the HEDIS 2007 Annual Dental Visit measure. Figure 3 illustrates the differences between the rates reported to the SPHA and those calculated by the EQRO for Annual Dental Visit calculations. The EQRO was 32.44%, while the rate reported by MO HealthNet Managed Care health plans was 32.50%, a 0.06% overestimate.

Figure 3 - Rates Reported by MO HealthNet MCHPs and Validated by EQRO, HEDIS 2007 Annual Dental Visit Measure



Sources: MO HealthNet MCHP HEDIS 2007 Data Submission Tool (DST); BHC, Inc. 2007 External Quality Review Performance Measure Validation.

HEDIS 2007 ADOLESCENT WELL-CARE VISITS

Data Integration and Control

The objective of this activity was to assess the MO HealthNet Managed Care health plans' ability to link data from multiple sources for the calculation of the HEDIS 2007 Adolescent Well-Care Visits measure. It is related to the integrity of the management information systems and the ability to ensure accuracy of the measures. For the HEDIS 2007 Adolescent Well-Care Visits measure, the sources of data included enrollment, eligibility, and claim files. Table 17 summarizes the findings of Attachment V (Data Integration and Control Findings) of the CMS Protocol. The rate of items that were Met was calculated across MO HealthNet Managed Care health plans and from the number of applicable items for each health plan.

No data integration and control issues were discovered by the EQRO. All MO HealthNet Managed Care health plans (100.0%) met the criteria for all areas of data integration and control.

Table 17 - Data Integration and Control Findings, HEDIS 2007 Adolescent Well-Care Visits

Item	Audit Elements	MO HealthNet MCHP							All MO HealthNet MCHPs		
		BA+	CMFHP	HCUSA	MCP	MOCare	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
5.1	MCHP/PIHP processes accurately and completely transfer data from the transaction files (e.g., membership, provider, encounter/claims) into the repository used to keep the data until the calculations of the performance measures have been completed and validated.	2	2	2	2	2	5	0	0	5	100.0%
5.2	Samples of data from repository are complete and accurate.	2	2	2	2	2	5	0	0	5	100.0%
5.3	MCHP's/PIHP's processes to consolidate diversified files, and to extract required information from the performance measure repository are appropriate.	2	2	2	2	2	5	0	0	5	100.0%
5.4	Actual results of file consolidations or extracts were consistent with those which should have resulted according to documented algorithms or specifications.	2	2	2	2	2	5	0	0	5	100.0%
5.5	Procedures for coordinating the activities of multiple subcontractors ensure the accurate, timely, and complete integration of data into the performance measure database.	2	2	2	2	2	5	0	0	5	100.0%
5.6	Computer program reports or documentation reflect vendor coordination activities, and no data necessary to performance measure reporting are lost or inappropriately modified during transfer.	2	2	2	2	2	5	0	0	5	100.0%
5.7	The repository's design, program flow charts, and source codes enable analyses and reports.	2	2	2	2	2	5	0	0	5	100.0%
5.8	Proper linkage mechanisms have been employed to join data from all necessary sources (e.g., identifying a member with a given disease/condition).	2	2	2	2	2	5	0	0	5	100.0%
5.9	Examine and assess the adequacy of the documentation governing the production process, including MCHP/PIHP production activity logs, and MCHP/PIHP staff review of report runs.	2	2	2	2	2	5	0	0	5	100.0%
5.10	Prescribed data cutoff dates were followed.	2	2	2	2	2	5	0	0	5	100.0%
5.11	The MCHP/PIHP has retained copies of files or databases used for performance measure reporting, in the event that results need to be reproduced.	2	2	2	2	2	5	0	0	5	100.0%
5.12	Review documentation standards to determine the extent to which the reporting software program is properly documented with respect to every aspect of the performance measurement reporting repository, including building, maintaining, managing, testing, and report production.	2	2	2	2	2	5	0	0	5	100.0%
5.13	Review the MCHP's/PIHP's processes and documentation to determine the extent to which they comply with the MCHP/PIHP standards associated with reporting program specifications, code review, and testing.	2	2	2	2	2	5	0	0	5	100.0%
	Number Met	13	13	13	13	13	65	0	0	65	100.0%
	Number Partially Met	0	0	0	0	0					
	Number Not Met	0	0	0	0	0					
	Number Applicable	13	13	13	13	13					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met ; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.

Source: BHC, Inc. 2007 External Quality Review Performance Measure Validation



Documentation of Data and Processes

The objectives of this activity were to assess the documentation of data collection; the process of integrating data into a performance measure set; the procedures used to query the data set for sampling, numerators and denominators; and the ability to apply proper algorithms for the calculation of HEDIS 2007 Adolescent Well-Care Visits measure. Table 18 summarizes the findings of Attachment VI (Data and Processes Used to Calculate and Report Performance Measures) of the CMS Protocol. Item 7.2 did not apply to any MO HealthNet Managed Care health plans for this measure, as none of the MCOs used non-standard codes. Items 7.3 (statistical testing of results and corrections made after processing), 7.4 (inclusion of external data sources), and 7.9 (consistent data from measure to measure) did not apply to this measure. Items 7.5, 7.7, and 7.10 are only applicable for the Hybrid method of calculation, and therefore did not apply to Blue-Advantage Plus of Kansas City, HealthCare USA, or Mercy CarePlus. Each MO HealthNet Managed Care health plan calculating the measure Met 100.0% of the criteria for processes used to calculate and report the HEDIS 2007 Adolescent Well-Care Visits measure.

Table 18 - Data and Processes Used to Calculate and Report Performance Measures, HEDIS 2007 Adolescent Well-Care Visits Measure

Item	Audit Elements	MO HealthNet MCHP					All MO HealthNet MCHPs				
		BA+	CMFHP	HCUSA	MCP	MOCare	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
7.1	Data file and field definitions used for each measure.	2	2	2	2	2	5	0	0	5	100.0%
7.2	Maps to standard coding if not used in original data collection.	NA	NA	NA	NA	NA	0	0	0	0	NA
7.3	Statistical testing of results and any corrections or adjustments made after processing.	NA	NA	NA	NA	NA	0	0	0	0	NA
7.4	All data sources, including external data (whether from a vendor, public registry, or other outside source), and any prior years' data (if applicable).	NA	NA	NA	NA	NA	0	0	0	0	NA
7.5	Detailed medical record review methods and practices, including the qualifications of medical record review supervisor and staff; reviewer training materials; audit tools used, including completed copies of each record-level reviewer determination; all case-level critical performance measure data elements used to determine a positive or negative event or exclude a case from same; and inter-rater reliability testing procedures and results.	NA	2	NA	NA	2	2	0	0	2	100.0%
7.6	Detailed computer queries, programming logic, or source code used to identify the population or sample for the denominator and/or numerator.	2	2	2	2	2	5	0	0	5	100.0%
7.7	If sampling used, description of sampling techniques, and documentation that assures the reviewer that samples used for baseline and repeat measurements of the performance measures were chosen using the same sampling frame and methodology.	NA	2	NA	NA	2	2	0	0	2	100.0%
7.8	Documentation of calculation for changes in performance from previous periods (if applicable), including statistical tests of significance.	2	2	2	2	2	5	0	0	5	100.0%
7.9	Data that are related from measure to measure are consistent (e.g., membership counts, provider totals, number of pregnancies and births).	NA	NA	NA	NA	NA	0	0	0	0	NA
7.10	Appropriate statistical functions are used to determine confidence intervals when sampling is used in the measure.	NA	2	NA	NA	2	2	0	0	2	100.0%
7.11	When determining improvement in performance between measurement periods, appropriate statistical methodology is applied to determine levels of significance of changes.	2	2	2	2	2	5	0	0	5	100.0%
	Number Met	4	7	4	4	7	26	0	0	26	100.0%
	Number Partially Met	0	0	0	0	0					
	Number Not Met	0	0	0	0	0					
	Number Applicable	4	7	4	4	7					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met ; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.

Source: BHC, Inc. 2007 External Quality Review Performance Measure Validation

Processes Used to Produce Denominators

The objective of this activity was to determine the extent to which all eligible members were included in the denominator, evaluate the programming and logic source codes, and evaluate the specifications for each measure. For the HEDIS 2007 Adolescent Well-Care Visits measure, the sources of data include enrollment, eligibility, and claim files. Table 19 summarizes the findings of Attachment X (Denominator Validation Findings) of the CMS Protocol. Items 10.5 (Identification of gender of the member), 10.6 (calculation of member months or years), and 10.10 (Systems for estimating populations when they are unable to accurately be counted) were not applicable to the HEDIS 2007 Adolescent Well-Care Visits measure. All of the remaining criteria were Met by all of the MO HealthNet Managed Care health plans; 100.0% of the criteria were Met for the processes used to produce denominators.

Table 19 - Denominator Validation Findings, HEDIS 2007 Adolescent Well-Care Visits Measure

Item	Audit Elements	MO HealthNet MCHP					All MO HealthNet MCHPs				
		BA+	CMFHP	HCUSA	MCP	MOCare	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
10.1	All members who were eligible to receive the specified services were included in the initial population from which the final denominator was produced. This "at risk" population included both members who received the services, as well as those who did not. This same standard applies to provider groups or other relevant populations identified in the specifications of each performance measure.	2	2	2	2	2	5	0	0	5	100.0%
10.2	For each measure, programming logic or source code which identifies, tracks, and links member enrollment within and across product lines (e.g., Medicare and Medicaid), by age and sex, as well as through possible periods of enrollment and disenrollment, has been appropriately applied according to the specifications of each performance measure.	2	2	2	2	2	5	0	0	5	100.0%
10.3	Calculations of continuous enrollment criteria were correctly carried out and applied to each measure (if applicable).	2	2	2	2	2	5	0	0	5	100.0%
10.4	Proper mathematical operations were used to determine patient age or range.	2	2	2	2	2	5	0	0	5	100.0%
10.5	The MCHP/PIHP can identify the variable(s) that define the member's sex in every file or algorithm needed to calculate the performance measure denominator, and the MCHP/PIHP can explain what classification is carried out if neither of the required codes is present.	NA	NA	NA	NA	NA	0	0	0	0	NA
10.6	The MCHP/PIHP has correctly calculated member months and member years, if applicable to the performance measure.	NA	NA	NA	NA	NA	0	0	0	0	NA
10.7	The MCHP/PIHP has properly evaluated the completeness and accuracy of any codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and these codes have been appropriately identified and applied as specified in each performance measure.	2	2	2	2	2	5	0	0	5	100.0%
10.8	Any time parameters required by the specifications of the performance measure are followed (e.g., cut off dates for data collection, counting 30 calendar days after discharge from a hospital, etc.).	2	2	2	2	2	5	0	0	5	100.0%
10.9	members from a denominator were followed. For example, if a measure relates to receipt of a specific service, the denominator may need to be adjusted to reflect instances in which the patient refuses the service or the service is contraindicated.	2	2	2	2	2	5	0	0	5	100.0%
10.10	Systems or methods used by the MCHP/PIHP to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.	NA	NA	NA	NA	NA	0	0	0	0	NA
	Number Met	7	7	7	7	7	35	0	0	35	100.0%
	Number Partially Met	0	0	0	0	0					
	Number Not Met	0	0	0	0	0					
	Number Applicable	7	7	7	7	7					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%					

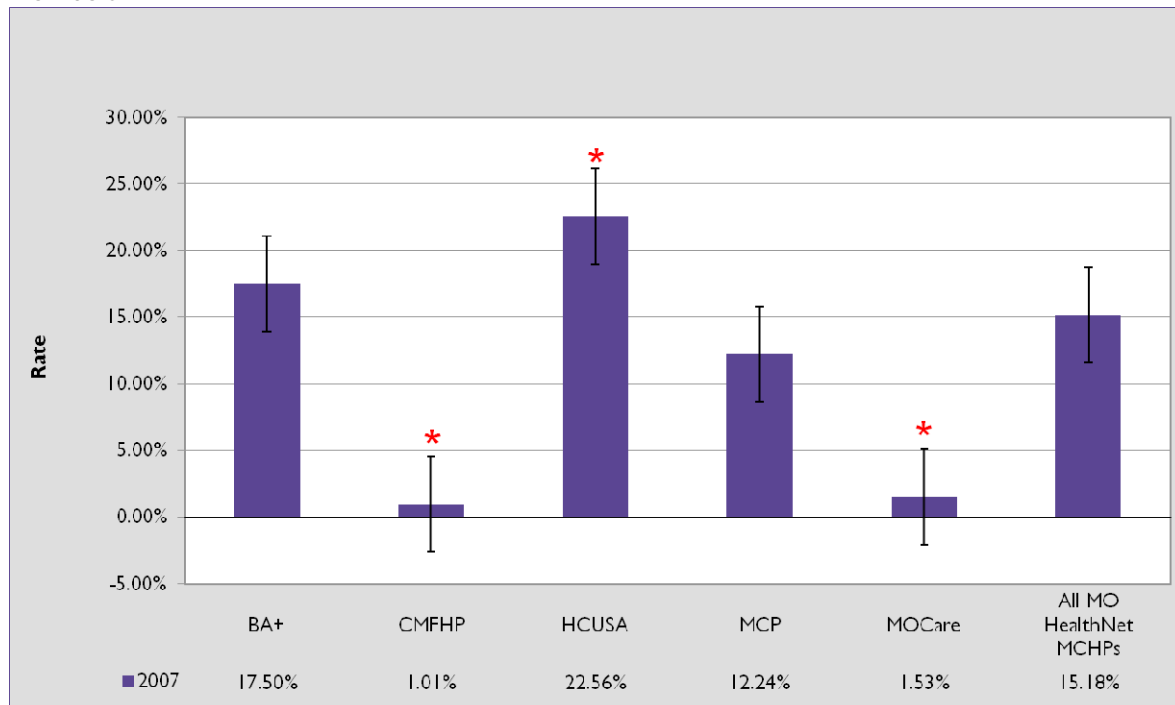
Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met ; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.

Source: BHC, Inc. 2007 External Quality Review Performance Measure Validation.



Figure 4 illustrates the rate of eligible members identified by each MO HealthNet Managed Care health plan, based on the enrollment of all MO HealthNet Managed Care members as of December 31, 2006 (the end of the CY2006 measurement year). It was expected that MO HealthNet Managed Care health plans would identify similar proportions of eligible members for the HEDIS 2007 Adolescent Well-Care Visits measure. The rate of eligible members (percent of eligible members divided by the total enrollment) was calculated for all MO HealthNet Managed Care health plans and two-tailed z-tests of each health plan compared to the state rate of eligible members were conducted at the 95% level of confidence. Children's Mercy Family Health Partners (1.01%) and MO Care (1.53%) identified rates that were significantly lower than the MO HealthNet Managed Care health plan average (15.18%). The percentage of eligible members identified by Healthcare USA (22.56%) was significantly higher than the MO HealthNet Managed Care average.

Figure 4 - MO HealthNet Managed Care Program HEDIS 2007 Adolescent Well-Care Visits, Eligible Members



Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance. Enrollment as of the last week in December 2006 (the measurement year) was used to calculate the rate.

Sources: MO HealthNet MCHP HEDIS 2007 Data Submission Tool (DST); Missouri Department of Social

Services, Division of Medical Services, State MPRI Session Screens, enrollment figures for all Waivers, December 31, 2006.

Processes Used to Produce Numerators

The objectives of this activity were to evaluate the MO HealthNet Managed Care health plans' ability to accurately identify medical events, evaluate the ability to identify events from other sources, evaluate procedures for non-duplicate counting of multiple events, review time parameters and the use of non-standard code maps, and assess the processes and procedures for collecting and incorporating medical record review data. For the HEDIS 2007 Adolescent Well-Care Visits measure, the sources of data included enrollment, eligibility, and claim files. Table 20 shows the numerators, denominators, rates, and confidence intervals submitted by the MO HealthNet Managed Care health plans to the SPHA on the DST. The "combined" rate for HealthCare USA was calculated by the EQRO based on reported rates for each region (Central, Eastern, and Western); thus, there is no confidence interval to report. The EQRO also calculated the rate for all MO HealthNet Managed Care health plans; this statewide rate also does not have a confidence interval reported. The rate for all MO HealthNet Managed Care health plans was 34.81%, with health plan rates ranging from 29.49% (Mercy CarePlus) to 44.91% (Missouri Care).

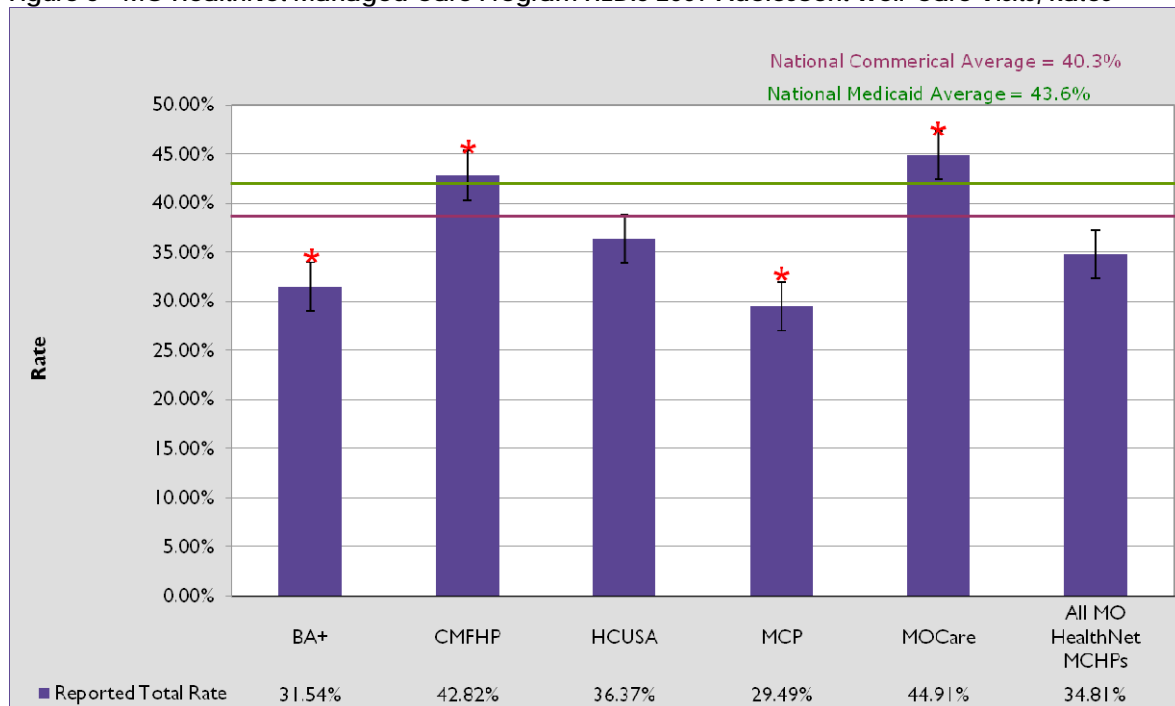
Table 20 - Data Submission for HEDIS 2007 Adolescent Well-Care Visits Measure

MO HealthNet MCHP	Final Data Collection Method Used	Denominator (DST)	Administrative Hits Reported by MCHP (DST)	Hybrid Hits Reported by MCHP (DST)	Total Hits Reported by MCHP (DST)	Rate Reported by MCHP (DST)	LCL - UCL (DST)
Blue Advantage Plus	Administrative	4,613	1,455	NA	1,455	31.54%	30.20% - 32.88%
Childrens Mercy Family Health Partners	Hybrid	411	133	43	176	42.82%	41.77% - 43.88%
HealthCare USA	Administrative	33,762	12,279	NA	12,279	36.37%	
Mercy CarePlus	Administrative	8470	2498	NA	2498	29.49%	28.52% - 30.47%
Missouri Care	Hybrid	432	158	36	194	44.91%	40.10% - 49.71%
All MO HealthNet MCHPs		47,688	16,523	79	16,602	34.81%	

Note: DST = Data Submission Tool; NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); LCL = 95% Lower Confidence Limit; UCL = 95% Upper Confidence Limit. The statewide rate for all MO HealthNet MCHPs was calculated by the EQRO using the sum of numerators divided by sum of denominators. There was no statewide rate or confidence limits reported to the SMA or SPHA.
Source: MO HealthNet Managed Care Organization HEDIS 2007 Data Submission Tools (DST)

Figure 5, Figure 6, and Figure 7 illustrate the rates reported by the MO HealthNet Managed Care health plans and the rates of administrative and hybrid hits for each MO HealthNet Managed Care health plan. The rate reported by each health plan was compared with the rate for all MO HealthNet Managed Care health plans. Two-tailed z-tests of each MO HealthNet Managed Care health plan comparing MO HealthNet Managed Care health plans to the rate for all MO HealthNet Managed Care health plans were calculated at the 95% confidence interval. Just as found during the 2004 EQR, the last time this measure was audited, the rate for all health plans (30.13%) was lower than both the National Medicaid rate (43.6%) and the National Commercial Rate (40.3%). However, the 2007 rate for all health plans (34.81%) is significantly higher than the 2004 rate for all health plans (30.13%), thereby showing an increased level of Adolescent Well-Care Visits being delivered throughout regions. The rates for Children's Mercy Family Health Partners (42.82%) and Missouri Care (44.91%) were significantly higher than the average. Both of these rates (CMFHP and MOCare) were also higher than the National Commercial Rate, but only Missouri Care reported a rate higher than the National Medicaid Rate. In 2004, Missouri Care also reported a rate higher than both the National Medicaid Rate and National Commercial Rate. Blue-Advantage Plus of Kansas City and Mercy CarePlus reported rates (31.54% and 29.49%, respectively) that were significantly lower than the statewide rate for all MO HealthNet Managed Care health plans.

Figure 5 - MO HealthNet Managed Care Program HEDIS 2007 Adolescent Well-Care Visits, Rates

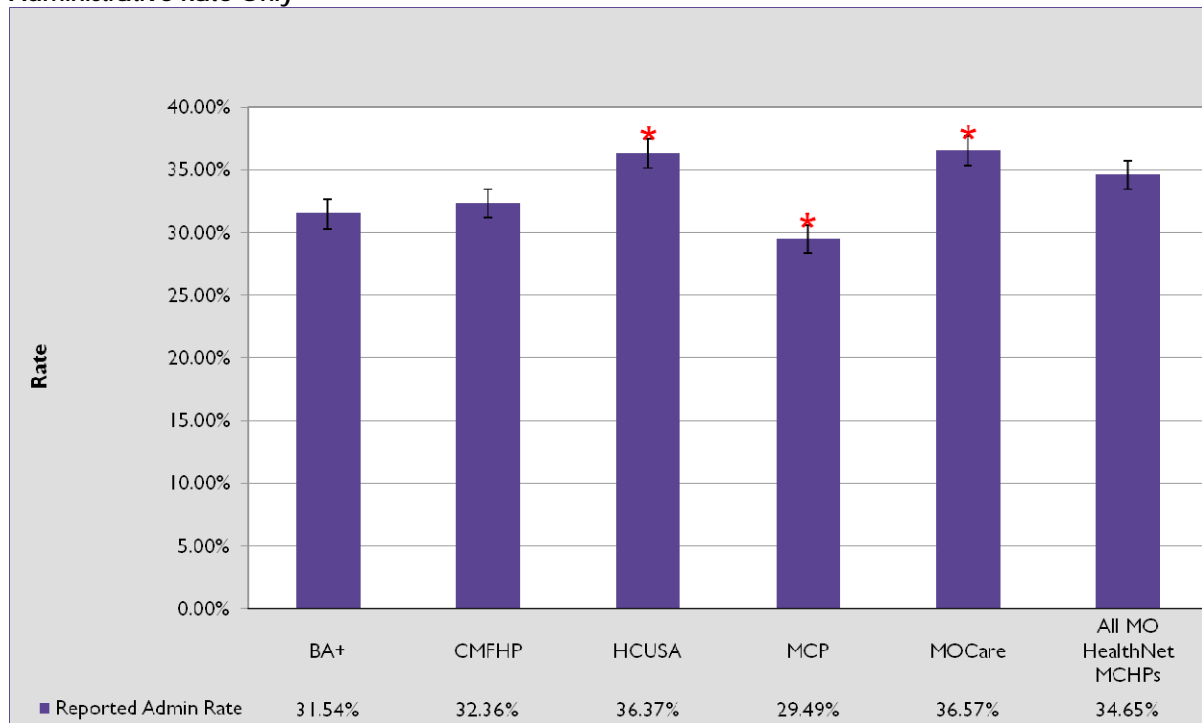


Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance.

Sources: MO HealthNet MCHP HEDIS 2007 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

When the rate of administrative and hybrid hits was examined separately, there did not appear to be a great deal of variability among MO HealthNet Managed Care health plans from the administrative rate for all MO HealthNet Managed Care health plans (34.65%). Rates ranged from 29.49% (Mercy CarePlus) to 36.57% (Missouri Care). Statistically, the rate reported by Mercy CarePlus was significantly lower than the statewide rate for all health plans; the rates for Healthcare USA and Missouri Care were significantly higher than the average rate.

Figure 6 - MO HealthNet Managed Care Program HEDIS 2007 Adolescent Well-Care Visits, Administrative Rate Only

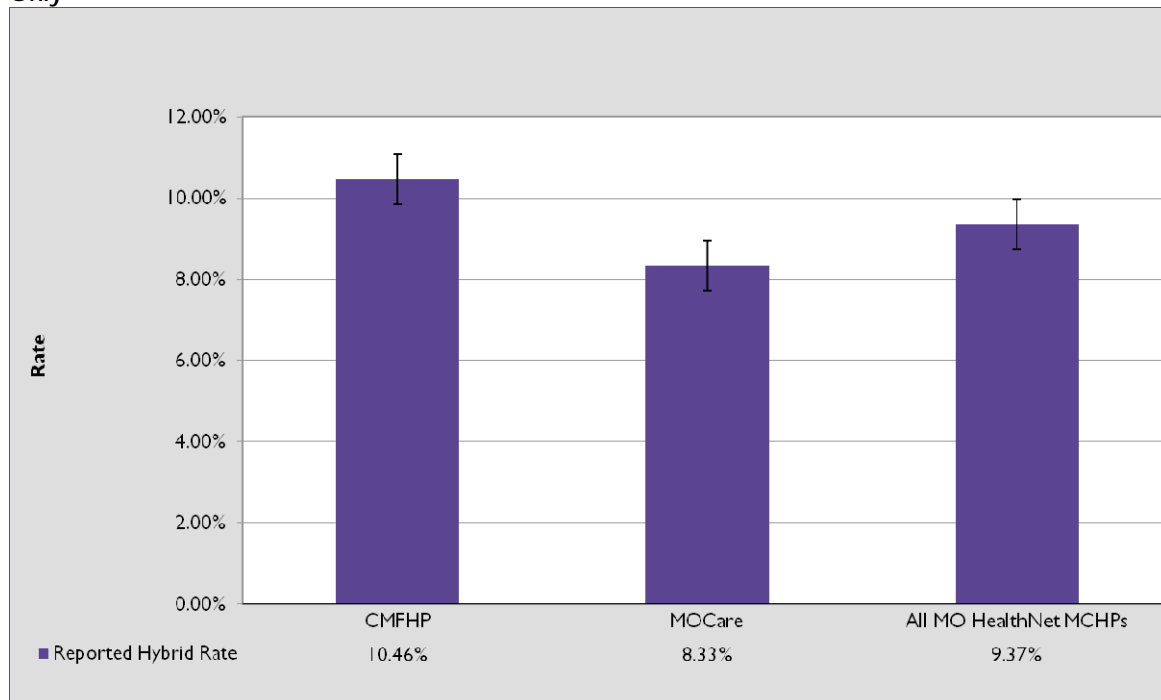


Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance.

Sources: MO HealthNet MCHP HEDIS 2007 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA).

Only two of the five MO HealthNet Managed Care health plans calculated the Adolescent Well-Care Visits measure hybridly. There were no statistically significant differences found in these rates.

Figure 7 - MO HealthNet Managed Care Program HEDIS 2007 Adolescent Well-Care Visits, Hybrid Rate Only



Note: Error bars on the y-axis represent 95% confidence intervals

Sources: MO HealthNet MCHP HEDIS 2007 Data Submission Tool (DST); National Committee for Quality Assurance (NCQA)

Table 21 and Table 22 summarize the findings of the EQRO medical record review validation and Attachment XII (Impact of Medical Record Findings) of the CMS Protocol. Two of the MO HealthNet Managed Care health plans (Children's Mercy Family Health Partners and Missouri Care) used the Hybrid Method of calculation. Children's Mercy Family Health Partners selected a sample of 411 eligible members, consistent with HEDIS technical specifications. Missouri Care selected a sample of 432 eligible members, as determined by the number of eligible members and in accordance with HEDIS technical specifications. A total of 60 of the 79 reported medical record hybrid hits by MO HealthNet Managed Care health plans were sampled for validation by the EQRO. Of the records requested, all 60 were received for review. The EQRO was able to validate 59 of the 60 records received, an Error Rate of 1.7% across all MO HealthNet Managed Care health plans. The number of False Positive Records (the total amount that could not be validated) was 1 of the 79 reported hits. The estimated bias for individual MO HealthNet Managed Care health plans based on the medical record validation ranged from a 0.0% to 0.3% overestimate in the rate, with an average overestimate of 0.2% for all health plans. Table 22 shows the impact of the medical record review findings.

Table 21 - Medical Record Validation for HEDIS 2007 Adolescent Well-Care Visits Measure

MO HealthNet MCHP	Denominator (Sample Size)	Numerator Hits by Medical Records (DST)	Medical Records Sampled for Audit by EQRO	Number Medical Records Received for Audit by EQRO	Number Medical Records Validated by EQRO	Rate Validated of Records Received	Accuracy Rate
Childrens Mercy Family Health Partners	411	43	30	30	29	96.7%	96.7%
Missouri Care	432	36	30	30	30	100.0%	100.0%
All MO HealthNet MCHPs	843	79	60	60	59	98.3%	98.3%

Note: DST = Data Submission Tool; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); Accuracy Rate = Number of Medical Records Validated by the EQRO/Number of Records Selected for Audit by EQRO; Error Rate = 100% - Accuracy Rate; Weight of Each Medical Record = 100% / Denominator (Sample Size); False Positive Records = Error Rate * Numerator Hits Reported by MCHP (DST); Estimated Bias from Medical Records = Percent of bias due to the medical record review = False Positive Rate * Weight of Each Medical Record.

Source: MO HealthNet MCHP Data Submission Tools (DST); BHC, Inc. 2007 External Quality Review Performance Measures Validation.

Table 22 - Impact of Medical Record Findings, HEDIS 2007 Adolescent Well-Care Visits Measure

Item	Audit Elements	MO HealthNet MCHP				
		BA +	CMFHP	HCUSA	MCP	MOCare
12.1	Final Data Collection Method Used (e.g., MRR, hybrid,)	Administrative	Hybrid	Administrative	Administrative	Hybrid
12.2	Error Rate (Percentage of records selected for audit that were identified as not meeting numerator requirements)	NA	2.33%	NA	NA	0.00%
12.3	Is error rate < 10%? (Yes or No)	NA	Yes	NA	NA	Yes
	If yes, MCHP/PIHP passes MRR validation; no further MRR calculations are necessary.	NA	Passes	NA	NA	Passes
	If no, the rest of the spreadsheet will be completed to determine the impact on the final rate.	NA	NA	NA	NA	NA
12.4	Denominator (The total number of members identified for the denominator of this measure, as identified by the MCHP/PIHP)	5541	411	33762	8470	432
12.5	Weight of Each Medical Record (Impact of each medical record on the final overall rate; determined by dividing 100% by the denominator)	NA	NA	NA	NA	NA
12.6	Total Number of MRR Numerator Positives identified by the MCHP/PIHP using MRR.	NA	NA	NA	NA	NA
12.7	Expected Number of False Positives (Estimated number of medical records inappropriately counted as numerator positives)	NA	NA	NA	NA	NA
12.8	Estimated Bias in Final Rate (The amount of bias caused by medical record review)	NA	NA	NA	NA	NA

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the Health Plan; Administrative Method was used by the Health Plan and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper

explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation.

Source: BHC, Inc. 2006 External Quality Review Performance Measure Validation.



Table 23 shows the validation of numerators based on the review of numerator extract files and the medical record review. Item 13.2 does not apply to this measure as is it unlikely members would receive Well-Care Visit services outside the health plan. Item 13.6 did not apply to any of the MO HealthNet Managed Care health plans, as none of the health plans used non-standard codes. Items 13.8 through 13.13 relate to the Hybrid Method and were not applicable to Blue-Advantage Plus of Kansas City, HealthCare USA, or Mercy CarePlus. Across MO HealthNet Managed Care health plans, 100% of the criteria for calculating numerators were met. All five (100%) of the health plans Met the criteria for using the appropriate data to identify the at-risk population, using complete medical event codes, correctly classifying members for inclusion in the numerator, eliminating or avoiding double-counting members, and following applicable time parameters. Two of the five health plans calculated this measure using the Hybrid Method (Missouri Care and Children’s Mercy Family Health Partners). Both Met all criteria (100.0%) relating to medical record reviews and data. The MO HealthNet Managed Care health plans Met 100.0% of criteria for calculating the numerator for the HEDIS 2007 Adolescent Well-Care measure.

Table 23 - Numerator Validation Findings, HEDIS 2007 Adolescent Well-Care Visits Measure

Item	Audit Elements	MO HealthNet MCHP					All MO HealthNet MCHPs				
		BA+	CMFHP	HCUSA	MCP	MOCare	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
13.1	The MCHP/PIHP has used the appropriate data, including linked data from separate data sets, to identify the entire at-risk population.	2	2	2	2	2	5	0	0	5	100.0%
13.2	The MCHP/PIHP has in place and utilizes procedures to capture data for those performance indicators that could be easily under-reported due to the availability of services outside the MCHP/PIHP.	NA	NA	NA	NA	NA	0	0	0	0	NA
13.3	The MCHP's/PIHP's use of codes used to identify medical events are complete, accurate, and specific in correctly describing what has transpired and when.	2	2	2	2	2	5	0	0	5	100.0%
13.4	The MCHP/PIHP correctly evaluated medical event codes when classifying members for inclusion or exclusion in the numerator.	2	2	2	2	2	5	0	0	5	100.0%
13.5	The MCHP/PIHP has avoided or eliminated all double-counted members or numerator events.	2	2	2	2	2	5	0	0	5	100.0%
13.6	Any non-standard codes used in determining the numerator have been mapped to a standard coding scheme in a manner that is consistent, complete, and reproducible as evidenced by a review of the programming logic or a demonstration of the program.	NA	NA	NA	NA	NA	0	0	0	0	NA
13.7	Any time parameters required by the specifications of the performance measure are adhered to (i.e., that the measured event occurred during the time period specified or defined in the performance measure).	2	2	2	2	2	5	0	0	5	100.0%
13.8	Medical record reviews and abstractions have been carried out in a manner that facilitates the collection of complete, accurate, and valid data.	NA	2	NA	NA	2	2	0	0	2	100.0%
13.9	Record review staff have been properly trained and supervised for the task.	NA	2	NA	NA	2	2	0	0	2	100.0%
13.10	Record abstraction tools require the appropriate notation that the measured event occurred.	NA	2	NA	NA	2	2	0	0	2	100.0%
13.11	Record abstraction tools require notation of the results or findings of the measured event (if applicable).	NA	2	NA	NA	2	2	0	0	2	100.0%
13.12	Data included in the record extract files are consistent with data found in the medical records as evidenced by a review of a sample of medical record for applicable performance measures. (From Medical Record Review Validation Tools)	NA	2	NA	NA	2	2	0	0	2	100.0%
13.13	The process of integrating administrative data and medical record data for the purpose of determining the numerator is consistent and valid.	NA	2	NA	NA	2	2	0	0	2	100.0%
	Number Met	5	11	5	5	11	37	0	0	37	100.0%
	Number Partially Met	0	0	0	0	0					
	Number Not Met	0	0	0	0	0					
	Number Applicable	5	11	5	5	11					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met ; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.

Source: BHC, Inc. 2007 External Quality Review Performance Measure Validation.



Sampling Procedures for Hybrid Method

The objectives of this activity were to evaluate the MO HealthNet Managed Care health plans' ability to randomly sample from the eligible members for the measure when using the Hybrid Method of calculation. Table 24 summarizes the findings of Attachment XV (Sampling Validation Findings) of the CMS Protocol. Items 15.3 (each provider had an equal chance of being sampled) and 15.9 (documenting if the requested sample size exceeded the eligible population size) did not apply to any of the MO HealthNet Managed Care health plans for this measure; and none of the items were applicable to Blue-Advantage Plus of Kansas City, HealthCare USA, or Mercy CarePlus. Across all MO HealthNet Managed Care health plans, the criteria for sampling were Met 100.0% of the time. The health plans using the Hybrid Method of calculating the HEDIS 2007 Adolescent Well-Care Visits measure Met 100.0% of the criteria for proper sampling.

Table 24 - Sampling Validation Findings, HEDIS 2007 Adolescent Well-Care Visits Measure

Item	Audit Elements	MO HealthNet MCHP					All MO HealthNet MCHPs				
		BA+	CMFHP	HCUSA	MCP	MOCare	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
15.1	Each relevant member or provider had an equal chance of being selected; no one was systematically excluded from the sampling.	NA	2	NA	NA	2	2	0	0	2	100.0%
15.2	The MCHP / PIHP followed the specifications set forth in the performance measure regarding the treatment of sample exclusions and replacements, and if any activity took place involving replacements of or exclusions from the sample, the MCHP/PIHP kept adequate documentation of that activity.	NA	2	NA	NA	2	2	0	0	2	100.0%
15.3	Each provider serving a given number of enrollees had the same probability of being selected as any other provider serving the same number of enrollees.	NA	NA	NA	NA	NA	0	0	0	0	NA
15.4	any bias was detected, the MCHP/PIHP is able to provide documentation that describes any efforts taken to correct it.	NA	2	NA	NA	2	2	0	0	2	100.0%
15.5	The sampling methodology employed treated all measures independently, and there is no correlation between drawn samples.	NA	2	NA	NA	2	2	0	0	2	100.0%
15.6	Relevant members or providers who were not included in the sample for the baseline measurement had the same chance of being selected for the follow-up measurement as providers who were included in the baseline.	NA	2	NA	NA	2	2	0	0	2	100.0%
15.7	The MCHP/PIHP has policies and procedures to maintain files from which the samples are drawn in order to keep the population intact in the event that a sample must be re-drawn, or replacements made, and documentation that the original population is intact.	NA	2	NA	NA	2	2	0	0	2	100.0%
15.8	Sample sizes meet the requirements of the performance measure specifications.	NA	2	NA	NA	2	2	0	0	2	100.0%
15.9	The MCHP/PIHP has appropriately handled the documentation and reporting of the measure if the requested sample size exceeds the population size.	NA	NA	NA	NA	NA	0	0	0	0	NA
15.10	The MCHP/PIHP properly oversampled in order to accommodate potential exclusions	NA	2	NA	NA	2	2	0	0	2	100.0%
15.11	Substitution applied only to those members who met the exclusion criteria specified in the performance measure definitions or requirements.	NA	2	NA	NA	2	2	0	0	2	100.0%
15.12	and the percentage of substituted records was documented.	NA	2	NA	NA	2	2	0	0	2	100.0%
	Number Met	0	10	0	0	10	20	0	0	20	100.0%
	Number Partially Met	0	0	0	0	0					
	Number Not Met	0	0	0	0	0					
	Number Applicable	0	10	0	0	10					
	Rate Met	NA	100.0%	NA	NA	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation.

Source: BHC, Inc. 2007 External Quality Review Performance Measure Validation



Submission of Measures to the State

Reports from the SPHA were obtained regarding the submission of the HEDIS 2007 Adolescent Well-Care Visits measure. All MO HealthNet Managed Care health plans reported the measure to the SPHA and SMA.

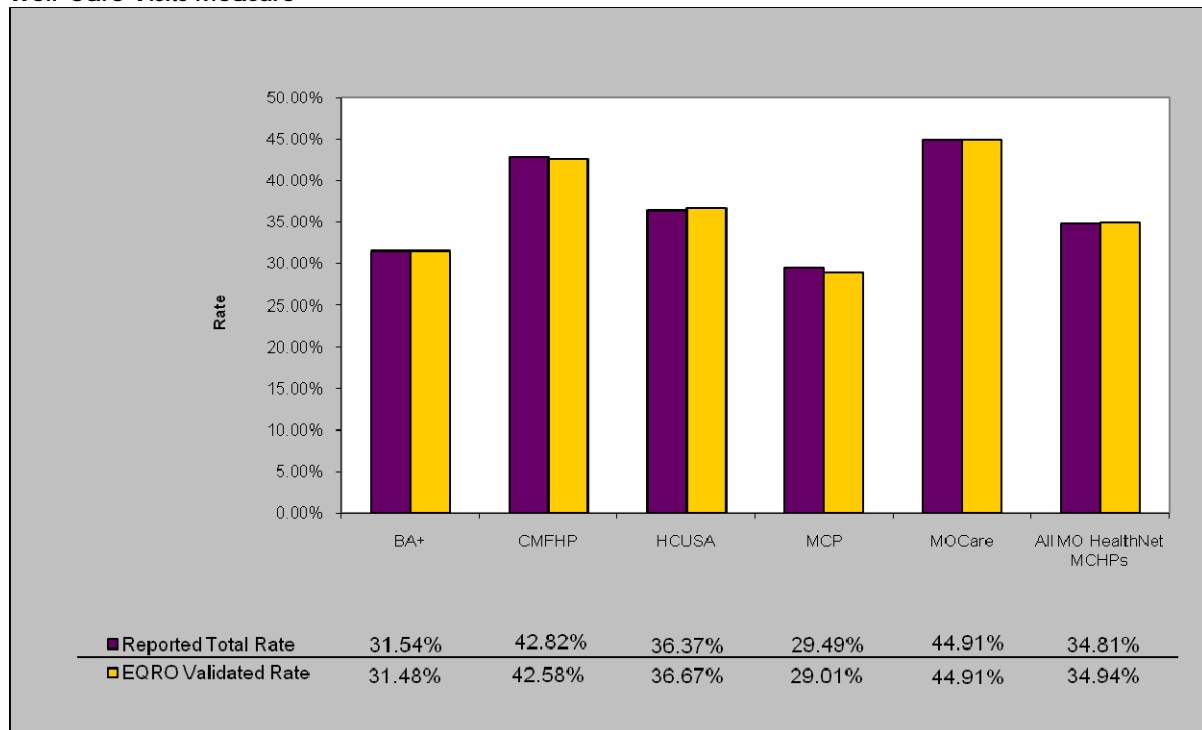
Final Validation Findings

Table 25 shows the final data validation findings for the calculation of the HEDIS 2007 Adolescent Well-Care Visits measure and the total estimated bias in calculation based on the validation of medical record data and review of the MO HealthNet Managed Care health plan extract files. Figure 8 illustrates the differences between the rates reported to the SPHA and those calculated by the EQRO. The rate for all MO HealthNet Managed Care health plans calculated based on data validated by the EQRO was 34.94%, while the rate reported by all health plans was 34.81%, a 0.13% underestimate.

Table 25 - Final Data Validation for HEDIS 2007 Adolescent Well-Care Visits Measure

MO HealthNet MCHP	Administrative Hits Validated by EQRO	Percentage of Medical Record Hits Validated by EQRO*	Total Hits Validated by EQRO	Rate Reported by MCHP (DST)	Rate Validated by EQRO	Total Estimated Bias
Blue Advantage Plus	1452	NA	1452	31.54%	31.48%	0.07%
Childrens Mercy Family Health Partners	133	96.67%	175	42.82%	42.58%	0.24%
HealthCare USA	12382	NA	12382	36.37%	36.67%	-0.31%
Mercy CarePlus	2457	NA	2457	29.49%	29.01%	0.48%
Missouri Care	158	100.00%	194	44.91%	44.91%	0.00%
All MO HealthNet MCHPs	16582		16660	34.81%	34.94%	-0.13%

Note: NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); DST = Data Submission Tool; Administrative/Medical Record Hits Validated by EQRO = Hits the EQRO was able to reproduce from the data provided by the MCHP; Total Hits Validated by EQRO = Administrative Hits Validated by EQRO + Medical Record Hits Validated by EQRO; False Positive Records = Error Rate * Rate Reported by MCHP; Rate Validated by EQRO = Total Hits Validated by EQRO / Denominator (DST); Total Estimated Bias = Rate Reported by MO HealthNet MCHP - Rate Validated by EQRO. Positive numbers represent an overestimate by the MCHP.

Figure 8 - Rates Reported by MO HealthNet MCOs and Validated by EQRO, HEDIS 2007 Adolescent Well-Care Visits Measure

Sources: MO HealthNet MCHP HEDIS 2007 Data Submission Tool (DST); BHC, Inc. 2007 External Quality Review Performance Measure Validation.

HEDIS 2007 FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

Data Integration and Control

The objective of this activity was to assess the MO HealthNet Managed Care health plans' ability to link data from multiple sources. It is based on the integrity of the management information systems and the ability to ensure accuracy of the measures. For the HEDIS 2007 Follow-up After Hospitalization for Mental Illness measure, the sources of data included enrollment, eligibility, and claim files. Table 26 summarizes the findings of Attachment V (Data Integration and Control Findings) of the CMS Protocol. The rate of items that were Met was calculated across MO HealthNet Managed Care health plans and from the number of applicable items for each MO HealthNet Managed Care health plan.

Across all MO HealthNet Managed Care health plans, 100.0% of the criteria were Met. Each MO HealthNet Managed Care health plan calculating the measure Met 100.0% of the criteria for data integration and control.

Table 26 - Data Integration and Control Findings, HEDIS 2007 Follow-up After Hospitalization for Mental Illness

Item	Audit Elements	MO HealthNet MCHP					All MO HealthNet MCHPs				
		BA +	CMFHP	HCUSA	MCP	MOCare	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
5.1	MCHP/PIHP processes accurately and completely transfer data from the transaction files (e.g., membership, provider, encounter/claims) into the repository used to keep the data until the calculations of the performance measures have been completed and validated.	2	2	2	2	2	5	0	0	5	100.0%
5.2	Samples of data from repository are complete and accurate.	2	2	2	2	2	5	0	0	5	100.0%
5.3	MCHP's/PIHP's processes to consolidate diversified files, and to extract required information from the performance measure repository are appropriate.	2	2	2	2	2	5	0	0	5	100.0%
5.4	Actual results of file consolidations or extracts were consistent with those which should have resulted according to documented algorithms or specifications.	2	2	2	2	2	5	0	0	5	100.0%
5.5	Procedures for coordinating the activities of multiple subcontractors ensure the accurate, timely, and complete integration of data into the performance measure database.	2	2	2	2	2	5	0	0	5	100.0%
5.6	Computer program reports or documentation reflect vendor coordination activities, and no data necessary to performance measure reporting are lost or inappropriately modified during transfer.	2	2	2	2	2	5	0	0	5	100.0%
5.7	The repository's design, program flow charts, and source codes enable analyses and reports.	2	2	2	2	2	5	0	0	5	100.0%
5.8	Proper linkage mechanisms have been employed to join data from all necessary sources (e.g., identifying a member with a given disease/condition).	2	2	2	2	2	5	0	0	5	100.0%
5.9	Examine and assess the adequacy of the documentation governing the production process, including MCHP/PIHP production activity logs, and MCHP/PIHP staff review of report runs.	2	2	2	2	2	5	0	0	5	100.0%
5.10	Prescribed data cutoff dates were followed.	2	2	2	2	2	5	0	0	5	100.0%
5.11	The MCHP/PIHP has retained copies of files or databases used for performance measure reporting, in the event that results need to be reproduced.	2	2	2	2	2	5	0	0	5	100.0%
5.12	Review documentation standards to determine the extent to which the reporting software program is properly documented with respect to every aspect of the performance measurement reporting repository, including building, maintaining, managing, testing, and report production.	2	2	2	2	2	5	0	0	5	100.0%
5.13	Review the MCHP's/PIHP's processes and documentation to determine the extent to which they comply with the MCHP/PIHP standards associated with reporting program specifications, code review, and testing.	2	2	2	2	2	5	0	0	5	100.0%
	Number Met	13	13	13	13	13	65	0	0	65	100.0%
	Number Partially Met	0	0	0	0	0					
	Number Not Met	0	0	0	0	0					
	Number Applicable	13	13	13	13	13					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met ; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the

measure being validated. Rate Met = Number Met / Number Applicable.

Source: BHC, Inc. 2007 External Quality Review Performance Measure Validation.



Documentation of Data and Processes

The objectives of this activity were to assess the documentation of data collection; the process of integrating data into a performance measure set; the procedures used to query the data set for sampling, numerators and denominators; and the ability to apply proper algorithms. Table 27 summarizes the findings of Attachment VI (Data and Processes Used to Calculate and Report Performance Measures) of the CMS Protocol. Item 7.2 did not apply as none of the MO HealthNet Managed Care health plans used non-standard codes. Item 7.4 is also not applicable as a member would not receive services for this measure outside of the MCO's system. Items 7.3 (statistical testing of results and corrections made after processing), 7.5 (detailed medical record review methods and practices), 7.7 (sampling techniques), 7.9 (data consistency from measure to measure), and 7.10 (appropriate statistical functions for confidence intervals) did not apply to the measure, as the measure must be calculated using only the Administrative method. All MO HealthNet Managed Care health plans Met 100.0% of the criteria for calculating and reporting performance measures.

Table 27 - Data and Processes Used to Calculate and Report Performance Measures, HEDIS 2007 Follow-up After Hospitalization for Mental Illness

Item	Audit Elements	MO HealthNet MCHP					All MO HealthNet MCHPs				
		BA+	CMFHP	HCUSA	MCP	MOCare	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
7.1	Data file and field definitions used for each measure.	2	2	2	2	2	5	0	0	5	100.0%
7.2	Maps to standard coding if not used in original data collection.	NA	NA	NA	NA	NA	0	0	0	0	NA
7.3	Statistical testing of results and any corrections or adjustments made after processing.	NA	NA	NA	NA	NA	0	0	0	0	NA
7.4	All data sources, including external data (whether from a vendor, public registry, or other outside source), and any prior years' data (if applicable).	NA	NA	NA	NA	NA	0	0	0	0	NA
7.5	Detailed medical record review methods and practices, including the qualifications of medical record review supervisor and staff; reviewer training materials; audit tools used, including completed copies of each record-level reviewer determination; all case-level critical performance measure data elements used to determine a positive or negative event or exclude a case from same; and inter-rater reliability testing procedures and results.	NA	NA	NA	NA	NA	0	0	0	0	NA
7.6	Detailed computer queries, programming logic, or source code used to identify the population or sample for the denominator and/or numerator.	2	2	2	2	2	5	0	0	5	100.0%
7.7	If sampling used, description of sampling techniques, and documentation that assures the reviewer that samples used for baseline and repeat measurements of the performance measures were chosen using the same sampling frame and methodology.	NA	NA	NA	NA	NA	0	0	0	0	NA
7.8	Documentation of calculation for changes in performance from previous periods (if applicable), including statistical tests of significance.	2	2	2	2	2	5	0	0	5	100.0%
7.9	Data that are related from measure to measure are consistent (e.g., membership counts, provider totals, number of pregnancies and births).	NA	NA	NA	NA	NA	0	0	0	0	NA
7.10	Appropriate statistical functions are used to determine confidence intervals when sampling is used in the measure.	NA	NA	NA	NA	NA	0	0	0	0	NA
7.11	When determining improvement in performance between measurement periods, appropriate statistical methodology is applied to determine levels of significance of changes.	2	2	2	2	2	5	0	0	5	100.0%
	Number Met	4	4	4	4	4	20	0	0	20	100.0%
	Number Partially Met	0	0	0	0	0					
	Number Not Met	0	0	0	0	0					
	Number Applicable	4	4	4	4	4					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met ; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the measure being validated. Rate Met = Number Met / Number Applicable.

Source: BHC, Inc. 2007 External Quality Review Performance Measure Validation.



Processes Used to Produce Denominators

The objective of this activity was to determine the extent to which all eligible members were included in the denominator, evaluate the programming and logic source codes, and evaluate the specifications for each measure. For the HEDIS 2007 Follow-up After Hospitalization for Mental Illness measure, the sources of data include enrollment, eligibility, and claim files. Table 28 summarizes the findings of Attachment X (Denominator Validation Findings) of the CMS Protocol. Items 10.5 (identification of gender of the member), 10.6 (calculation of member months or years), and 10.10 (systems for estimating populations when they are unable to accurately be counted) were not applicable to this measure. Across all MO HealthNet Managed Care health plans, 100.0% of criteria for calculating and reporting performance measures were Met. Each MO HealthNet Managed Care health plan Met 100.0% of the criteria for the process used to produce denominators.

Table 28 - Denominator Validation Findings, HEDIS 2007 Follow-up After Hospitalization for Mental Illness

Item	Audit Elements	MO HealthNet MCHP					All MO HealthNet MCHPs				
		BA+	CMFHP	HCUSA	MCP	MOCare	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
10.1	All members who were eligible to receive the specified services were included in the initial population from which the final denominator was produced. This "at risk" population included both members who received the services, as well as those who did not. This same standard applies to provider groups or other relevant populations identified in the specifications of each performance measure.	2	2	2	2	2	5	0	0	5	100.0%
10.2	For each measure, programming logic or source code which identifies, tracks, and links member enrollment within and across product lines (e.g., Medicare and Medicaid), by age and sex, as well as through possible periods of enrollment and disenrollment, has been appropriately applied according to the specifications of each performance measure.	2	2	2	2	2	5	0	0	5	100.0%
10.3	Calculations of continuous enrollment criteria were correctly carried out and applied to each measure (if applicable).	2	2	2	2	2	5	0	0	5	100.0%
10.4	Proper mathematical operations were used to determine patient age or range.	2	2	2	2	2	5	0	0	5	100.0%
10.5	The MCHP/PIHP can identify the variable(s) that define the member's sex in every file or algorithm needed to calculate the performance measure denominator, and the MCHP/PIHP can explain what classification is carried out if neither of the required codes is present.*	NA	NA	NA	NA	NA	0	0	0	0	NA
10.6	The MCHP/PIHP has correctly calculated member months and member years, if applicable to the performance measure.*	NA	NA	NA	NA	NA	0	0	0	0	NA
10.7	The MCHP/PIHP has properly evaluated the completeness and accuracy of any codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and these codes have been appropriately identified and applied as specified in each performance measure.	2	2	2	2	2	5	0	0	5	100.0%
10.8	Any time parameters required by the specifications of the performance measure are followed (e.g., cut off dates for data collection, counting 30 calendar days after discharge from a hospital, etc.).	2	2	2	2	2	5	0	0	5	100.0%
10.9	members from a denominator were followed. For example, if a measure relates to receipt of a specific service, the denominator may need to be adjusted to reflect instances in which the patient refuses the service or the service is contraindicated.	2	2	2	2	2	5	0	0	5	100.0%
10.10	Systems or methods used by the MCHP/PIHP to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.*	NA	NA	NA	NA	NA	0	0	0	0	NA
	Number Met	7	7	7	7	7	35	0	0	35	100.0%
	Number Partially Met	0	0	0	0	0					
	Number Not Met	0	0	0	0	0					
	Number Applicable	7	7	7	7	7					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%					

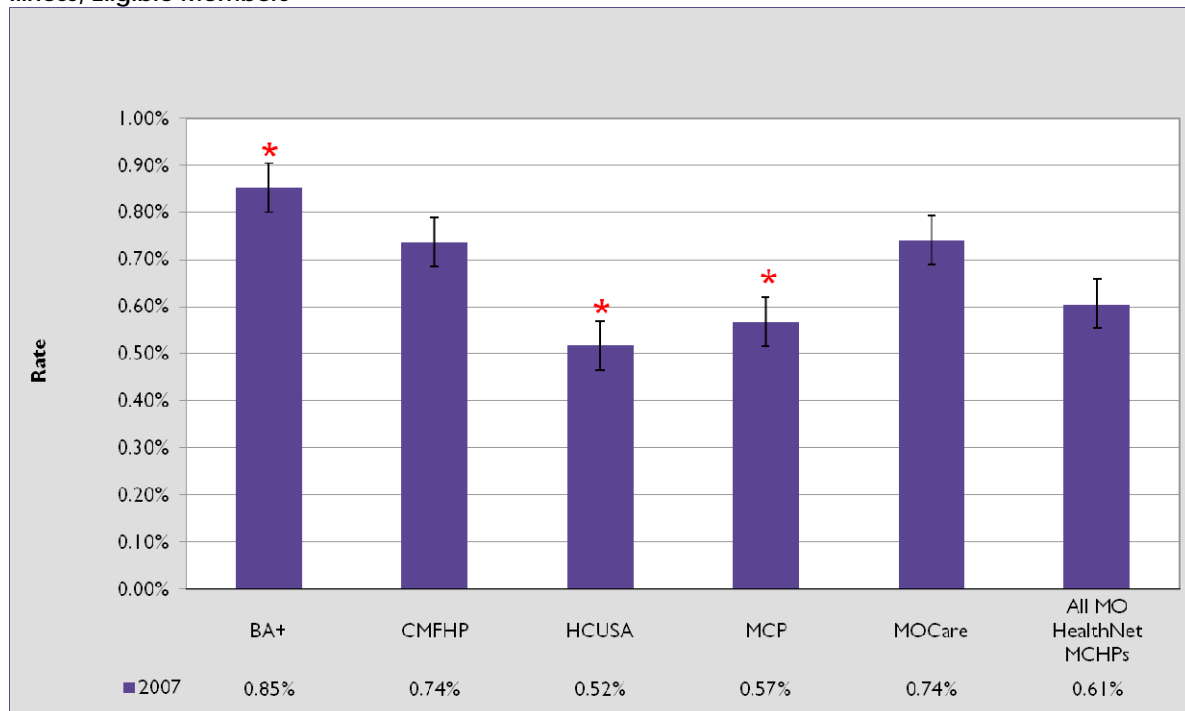
Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met ; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the

measure being validated. Rate Met = Number Met / Number Applicable.

Source: BHC, Inc. 2007 External Quality Review Performance Measure Validation.



Figure 9 illustrates the rate of eligible members per MO HealthNet Managed Care health plan based on the enrollment of all MO HealthNet Managed Care Waiver Members as of December 31, 2006 (the end of the CY2006 measurement year). It was expected that MO HealthNet Managed Care health plans would identify similar proportions of eligible members for the measure. The rate of eligible members (percent of eligible members divided by the total enrollment) was calculated for all MO HealthNet Managed Care health plans. Two-tailed z-tests of each MO HealthNet Managed Care health plan comparing each MO HealthNet Managed Care health plan to the state rate of eligible members for all MO HealthNet Managed Care health plans were calculated at the 95% level of confidence. HealthCare USA (0.52%) and Mercy CarePlus (0.57%) identified significantly lower rates than the statewide rate (0.61%) for all MO HealthNet Managed Care health plans. The percentage of eligible members reported by Blue-Advantage Plus of Kansas City (0.85%) was significantly higher than the average. This variability could be due to differences in the composition of these particular health plans' populations.

Figure 9 - MO HealthNet Managed Care Program HEDIS 2007 Follow-up After Hospitalization for Mental Illness, Eligible Members

Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance. Enrollment as of the last week in December 2006 (the measurement year) was used to calculate the rate.

Sources: MO HealthNet MCHP HEDIS 2007 Data Submission Tool (DST); Missouri Department of Social Services, Division of Medical Services, State MPRI Session Screens, enrollment figures for all Waivers, December 31, 2006.

Processes Used to Produce Numerators

The objectives of this activity were to evaluate the MO HealthNet Managed Care health plans ability to accurately identify medical events, evaluate the ability to identify events from other sources, evaluate procedures for non-duplicate counting of multiple events, review time parameters and the use of non-standard code maps, and assess the processes and procedures for collecting and incorporating medical record review data. For the HEDIS 2007 Follow-up After Hospitalization for Mental Illness measure, the procedures for the Hybrid Method did not apply, as HEDIS 2007 technical specifications allow only for the use of the Administrative Method of calculating the measure.

Table 29 and Table 30 show the numerators, denominators, rates, and confidence intervals submitted by the MO HealthNet Managed Care health plans to the SPHA

on the DST for the Follow-up After Hospitalization for Mental Illness measure.

Children's Mercy Family Health Partners did not report confidence intervals on the DST provided to the EQRO, and therefore this interval could not be reported.

HealthCare USA reported regional rates (Eastern, Central, and Western); the EQRO combined these rates to calculate a combined rate, and thus there is no confidence interval to report. Similarly, the rate for all MO HealthNet Managed Care health plans was calculated by the EQRO, and no confidence interval is included for the statewide rate.

Just as reported in 2006, the rate for all MO HealthNet Managed Care health plans was below both the National Medicaid Rate of 39.1% and the National Commercial Rate of 56.7%. The 7-Day reported rate for all MO HealthNet Managed Care health plans in 2007 was 35.52%, which was a 4.36% increase over the 7-day rate reported in 2006 (the last year this measure was audited by the EQR).

For 2007, the 30-Day reported rate for all MO HealthNet Managed Care health plans was 60.06%, higher than the National Medicaid rate (57.7%) but lower than the National Commercial average (75.8%). In 2006, the reported rate for all MO HealthNet Managed Care health plans was 52.92%, which was lower than both the National Medicaid rate and the National Commercial average and was also 7.14% lower than the 2007 rate.

Table 29 - Data Submission and Final Data Validation for HEDIS 2007 Follow-up After Hospitalization for Mental Illness Measure (7 days)

MO HealthNet MCHP	Eligible Population	Number Administrative Hits Reported by MCHP (DST)	Rate Reported by MCHP (DST)	LCL - UCL (DST)	Administrative Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Blue Advantage Plus	225	132	58.67%	52.01 - 65.32%	130	57.78%	0.89%
Childrens Mercy Family Health Partners	301	146	48.50%		144	47.84%	0.66%
HealthCare USA	775	212	27.35%		210	27.10%	0.26%
Mercy CarePlus	393	97	24.68%	20.29 - 29.07%	97	24.68%	0.00%
Missouri Care	209	89	42.58%	35.64 - 49.53%	89	42.58%	0.00%
All MO HealthNet MCHPs	1,903	676	35.52%		670	35.21%	0.32%

Note: DST = Data Submission Tool; NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); LCL = 95% Lower Confidence Limit; UCL = 95% Upper Confidence Limit. Rate Validated by EQRO = Administrative Hits Validated by EQRO / Eligible Population. Estimated Bias = Rate Reported by MCHP (DST) - Rate Validated by EQRO. Positive bias indicates an overestimate.

Source: MO HealthNet Managed Care Organization HEDIS 2007 Data Submission Tools (DST).

Table 30 - Data Submission and Final Data Validation for HEDIS 2007 Follow-up After Hospitalization for Mental Illness Measure (30 days)

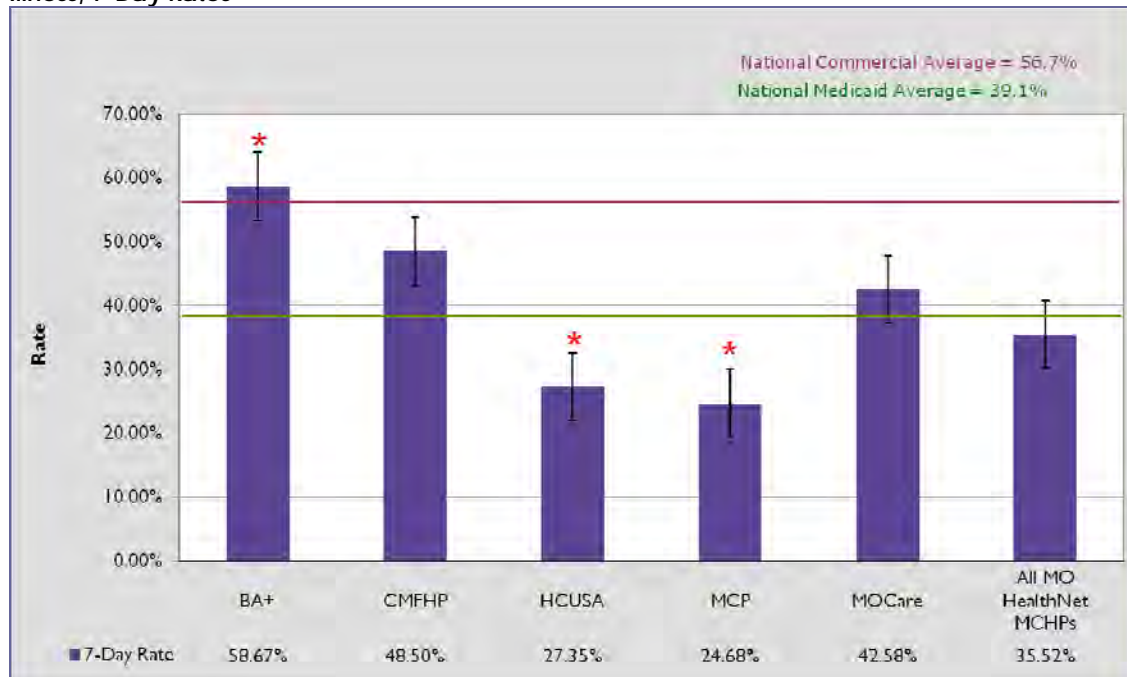
MO HealthNet MCHP	Eligible Population	Number Administrative Hits Reported by MCHP (DST)	Rate Reported by MCHP (DST)	LCL - UCL (DST)	Administrative Hits Validated by EQRO	Rate Validated by EQRO	Estimated Bias
Blue Advantage Plus	225	171	76.00%	70.20 - 81.80%	170	75.56%	0.44%
Childrens Mercy Family Health Partners	301	266	88.37%		265	88.04%	0.33%
HealthCare USA	775	392	50.58%		389	50.19%	0.39%
Mercy CarePlus	393	182	46.31%	41.25 - 51.37%	182	46.31%	0.00%
Missouri Care	209	132	63.16%	56.38 - 69.94%	131	62.68%	0.48%
All MO HealthNet MCHPs	1,903	1,143	60.06%		1,137	59.75%	0.32%

Note: DST = Data Submission Tool; NA = Not Applicable; EQRO = External Quality Review Organization (Behavioral Health Concepts, Inc.); LCL = 95% Lower Confidence Limit; UCL = 95% Upper Confidence Limit. Rate Validated by EQRO = Administrative Hits Validated by EQRO / Eligible Population. Estimated Bias = Rate Reported by MCHP (DST) - Rate Validated by EQRO. Positive bias indicates an overestimate.

Source: MO HealthNet Managed Care Organization HEDIS 2007 Data Submission Tools (DST).

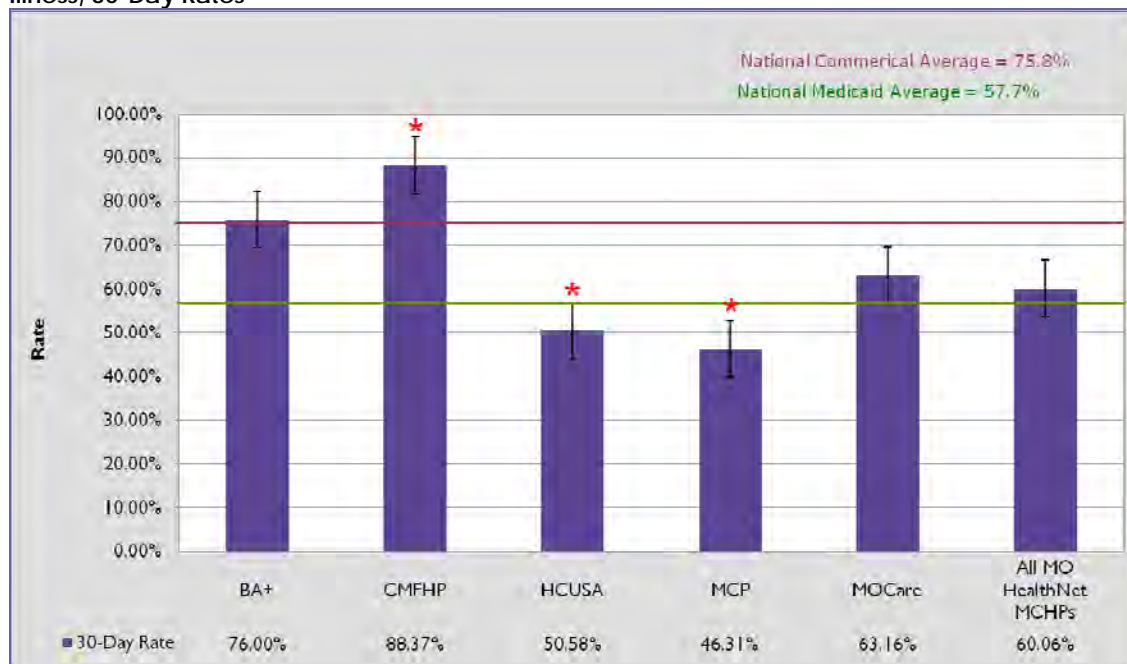
Figure 10 and Figure 11 illustrate the 7-Day and 30-Day rates reported by the MO HealthNet Managed Care health plans. The rate reported by each MO HealthNet Managed Care health plan was compared with the rate for all MO HealthNet Managed Care health plans, with two-tailed z-tests conducted at the 95% confidence interval to compare each MO HealthNet Managed Care health plan with the rate for all MO HealthNet Managed Care health plans. The 7-Day rates reported for Healthcare USA and Mercy CarePlus (27.35% and 24.68%, respectively) were significantly lower than the statewide rate for all MO HealthNet Managed Care health plans. Blue-Advantage Plus of Kansas City reported a rate (58.67%) significantly higher than the average. Blue-Advantage Plus of Kansas City, Children's Mercy Family Health Partners, and Missouri Care all reported rates higher than the National Medicaid Rate (39.1%) and the rate for Blue-Advantage Plus of Kansas City was also higher than the National Commercial Rate (56.7%).

The 30-Day rates reported for Blue-Advantage Plus of Kansas City, Children's Mercy Family Health Partners, and Missouri Care were all higher than both the statewide rate (60.06%) and the National Medicaid Rate (57.7%). Blue-Advantage Plus of Kansas City and Children's Mercy Family Health Partners were also higher than the National Commercial Rate (75.8%) and CMFHP was significantly higher than the average statewide rate for all MO HealthNet Managed Care health plans. Healthcare USA and Mercy CarePlus reported rates that were significantly lower than the statewide rate for all MO HealthNet Managed Care health plans (50.58% and 46.31% respectively).

Figure 10 - MO HealthNet Managed Care Program HEDIS 2007 Follow-up After Hospitalization for Mental Illness, 7-Day Rates

Note: Error bars on the y-axis represent 95% confidence intervals; * indicates values are significantly lower or higher than the MOHealthNet average at the 95% level of significance.

Sources: MO HealthNet MCHP HEDIS 2007 DST; National Committee for Quality Assurance (NCQA).

Figure 11 - MO HealthNet Managed Care Program HEDIS 2007 Follow-up After Hospitalization for Mental Illness, 30-Day Rates

Note: Error bars on the y-axis represent 95% confidence intervals.

Sources: MO HealthNet MCHP HEDIS 2007 DST; National Committee for Quality Assurance (NCQA).

Table 31 shows the validation of numerators based on the review of numerator extract files and the medical record review. Item 13.2 was not applicable to the HEDIS 2007 Follow-up After Hospitalization for Mental Illness measure. Item 13.6 did not apply, as none of the MO HealthNet Managed Care health plans used non-standard codes. Items 13.8 through 13.13 relate to the Hybrid Method of calculation and were not applicable to the measure. Across all MO HealthNet Managed Care health plans, 100% of the criteria for calculating numerators were met. Each of the MO HealthNet Managed Care health plans Met 100.0% of criteria for the calculation of the numerator.

Table 31 - Numerator Validation Findings, HEDIS 2007 Follow-up After Hospitalization for Mental Illness Measure

Item	Audit Elements	MO HealthNet MCHP					All MO HealthNet MCHPs				
		BA+	CMFHP	HCUSA	MCP	MOCare	Number Met	Number Partially Met	Number Not Met	Number Applicable	Rate Met
13.1	The MCHP/PIHP has used the appropriate data, including linked data from separate data sets, to identify the entire at-risk population.	2	2	2	2	2	5	0	0	5	100.0%
13.2	The MCHP/PIHP has in place and utilizes procedures to capture data for those performance indicators that could be easily under-reported due to the availability of services outside the MCHP/PIHP.	NA	NA	NA	NA	NA	0	0	0	0	NA
13.3	The MCHP's/PIHP's use of codes used to identify medical events are complete, accurate, and specific in correctly describing what has transpired and when.	2	2	2	2	2	5	0	0	5	100.0%
13.4	when classifying members for inclusion or exclusion in the numerator.	2	2	2	2	2	5	0	0	5	100.0%
13.5	The MCHP/PIHP has avoided or eliminated all double-counted members or numerator events.	2	2	2	2	2	5	0	0	5	100.0%
13.6	Any non-standard codes used in determining the numerator have been mapped to a standard coding scheme in a manner that is consistent, complete, and reproducible as evidenced by a review of the programming logic or a demonstration of the program.	NA	NA	NA	NA	NA	0	0	0	0	NA
13.7	Any time parameters required by the specifications of the performance measure are adhered to (i.e., that the measured event occurred during the time period specified or defined in the performance measure).	2	2	2	2	2	5	0	0	5	100.0%
13.8	Medical record reviews and abstractions have been carried out in a manner that facilitates the collection of complete, accurate, and valid data.	NA	NA	NA	NA	NA	0	0	0	0	NA
13.9	Record review staff have been properly trained and supervised for the task.	NA	NA	NA	NA	NA	0	0	0	0	NA
13.10	Record abstraction tools require the appropriate notation that the measured event occurred.	NA	NA	NA	NA	NA	0	0	0	0	NA
13.11	Record abstraction tools require notation of the results or findings of the measured event (if applicable).	NA	NA	NA	NA	NA	0	0	0	0	NA
13.12	Data included in the record extract files are consistent with data found in the medical records as evidenced by a review of a sample of medical record for applicable performance measures. (From Medical Record Review Validation Tools-Table 5, ATTACHMENT XII)	NA	NA	NA	NA	NA	0	0	0	0	NA
13.13	The process of integrating administrative data and medical record data for the purpose of determining the numerator is consistent and valid.	NA	NA	NA	NA	NA	0	0	0	0	NA
	Number Met	5	5	5	5	5	25	0	0	25	100.0%
	Number Partially Met	0	0	0	0	0					
	Number Not Met	0	0	0	0	0					
	Number Applicable	5	5	5	5	5					
	Rate Met	100.0%	100.0%	100.0%	100.0%	100.0%					

Note: A = Administrative; H = Hybrid; NA = Not Applicable to the method employed by the MO HealthNet MCHP; Administrative Method was used by the MO HealthNet MCHP and the item relates to the Hybrid Method; 2 = Met and validated through HEDIS software certification process and proper explanation in documentation or proper explanation in documentation. 1 = Partially Met ; 0 = Not Met, validated through HEDIS software certification process, but no proper explanation of the process in documentation or no or insufficient explanation in documentation. * Item is not applicable to the

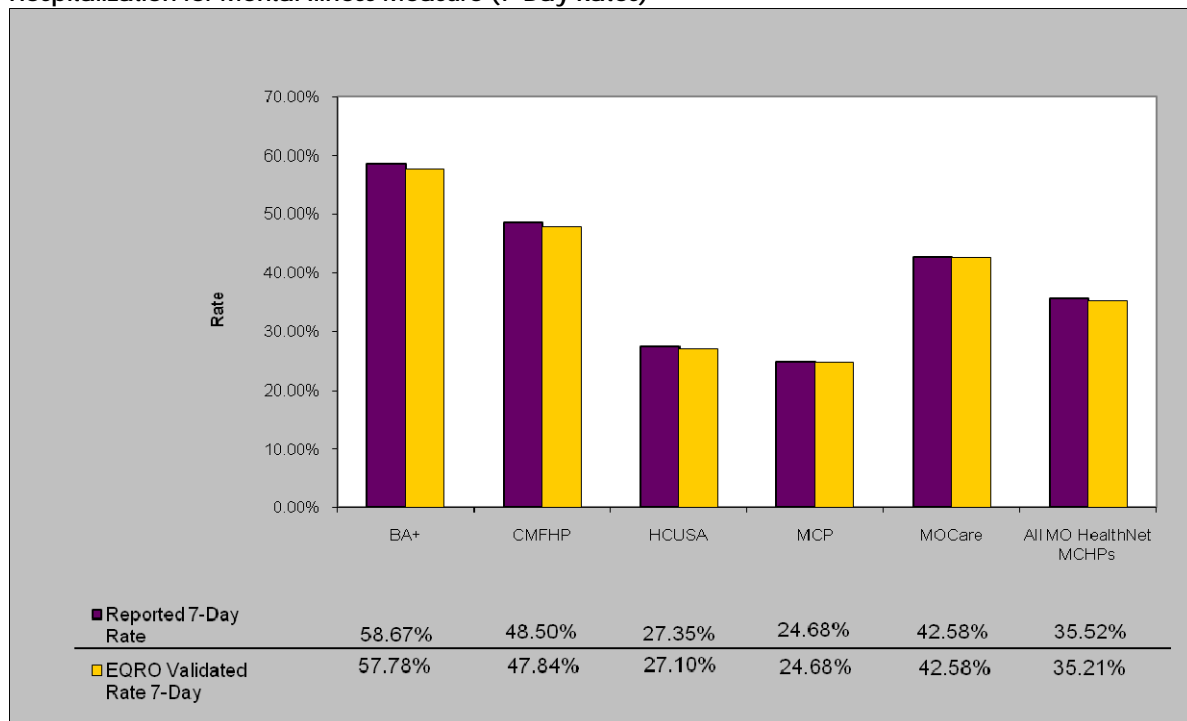
measure being validated. Rate Met = Number Met / Number Applicable.

Source: BHC, Inc. 2007 External Quality Review Performance Measure Validation.

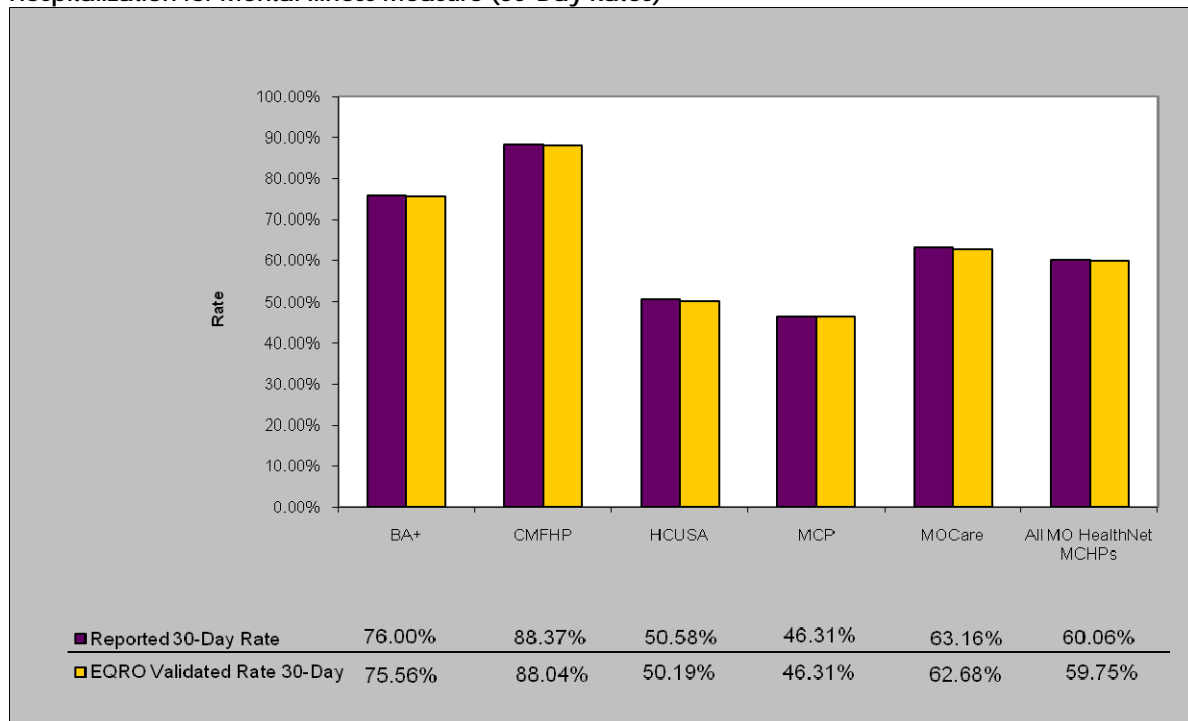
Submission of Measures to the State

Reports from the SPHA were obtained regarding the submission of the HEDIS 2007 Follow-up After Hospitalization for Mental Illness Measure. All MO HealthNet Managed Care health plans calculated and submitted the measure to the SPHA and SMA. The 7-Day rates reported by MO HealthNet Managed Care health plans ranged from 24.68% (Mercy CarePlus) to 58.76% (Blue-Advantage Plus of Kansas City). The rate of all MO HealthNet Managed Care health plans calculated based on data validated by the EQRO was 35.21%. The MO HealthNet Managed Care health plans reported an overall rate of 35.52%, a 0.31% overestimate (see Figure 12). The 30-Day rate reported by MO HealthNet Managed Care health plans ranged from 46.31% (Mercy CarePlus) to 88.37% (Children's Mercy Family Health Partners). The rate of all MO HealthNet Managed Care health plans calculated based on data validated by the EQRO was 59.75%. The rate reported by MO HealthNet Managed Care health plans was 60.06%, a 0.31% overestimate (see Figure 13).

Figure 12 - Rates Reported by MO HealthNet MCOs and Validated by EQRO, HEDIS 2007 Follow-up After Hospitalization for Mental Illness Measure (7-Day Rates)



Sources: MO HealthNet MCHP HEDIS 2007 Data Submission Tool (DST); BHC, Inc. 2007 External Quality Review Performance Measure Validation.

Figure 13 - Rates Reported by MO HealthNet MCOs and Validated by EQRO, HEDIS 2007 Follow-up After Hospitalization for Mental Illness Measure (30-Day Rates)

Sources: MO HealthNet MCHP HEDIS 2007 Data Submission Tool (DST); BHC, Inc. 2007 External Quality Review Performance Measure Validation.

Final Validation Findings

Table 32, Table 33, and Table 34 provide summaries of ratings across all Protocol Attachments for each MO HealthNet Managed Care health plan and measure validated. The rate of compliance with the calculation of each of the three performance measures was 100% across all MCOs. The EQRO found each MCO to be in complete compliance.

Table 32 - Summary of Attachment Ratings, HEDIS 2007 Annual Dental Visit Measure

All Audit Elements	All MO HealthNet MCOs					All MO HealthNet MCOs
	BA+	CMFHP	HCUSA	MCP	MOCare	
Number Met	30	30	30	30	30	150
Number Partially Met	0	0	0	0	0	0
Number Not Met	0	0	0	0	0	0
Number Applicable	30	30	30	30	30	150
Rate Met	100%	100%	100%	100%	100%	100.0%

Note: Rate Met = Number Met / Number Applicable.

Source: BHC, Inc. 2007 External Quality Review Performance Measure Validation

Table 33 - Summary of Attachment Ratings, HEDIS 2007 Adolescent Well-Care Measure

All Audit Elements	All MO HealthNet MCOs					All MO HealthNet MCOs
	BA+	CMFHP	HCUSA	MCP	MOCare	
Number Met	29	49	29	29	49	184
Number Partially Met	0	0	0	0	0	0
Number Not Met	0	0	0	0	0	0
Number Applicable	29	49	29	29	49	184
Rate Met	100%	100%	100%	100%	100%	100.0%

Note: Rate Met = Number Met / Number Applicable.

Source: BHC, Inc. 2007 External Quality Review Performance Measure Validation

Table 34 - Summary of Attachment Ratings, HEDIS 2007 Follow-up After Hospitalization for Mental Illness Measure

All Audit Elements	All MO HealthNet MCOs					All MO HealthNet MCOs
	BA+	CMFHP	HCUSA	MCP	MOCare	
Number Met	29	29	29	29	29	145
Number Partially Met	0	0	0	0	0	0
Number Not Met	0	0	0	0	0	0
Number Applicable	29	29	29	29	29	145
Rate Met	100%	100%	100%	100%	100%	100.0%

Note: Rate Met = Number Met / Number Applicable.

Source: BHC, Inc. 2007 External Quality Review Performance Measure Validation

Table 35 summarizes the final audit ratings for each of the performance measures and MO HealthNet Managed Care health plans. The final audit findings for each of the measures was based on the evaluation of processes for calculating and reporting the measures, medical record review validation findings, and MO HealthNet Managed Care health plan extract files from repositories. The ratings were based on the impact of medical record review findings and the degree of overestimation of the rate as validated by the EQRO. The calculation of measures was considered invalid if the specifications were not properly followed, or if the rate validated by the EQRO fell outside the confidence intervals for the measure reported by the MO HealthNet Managed Care health plans on the DST.

Table 35 - Summary of EQRO Final Audit Ratings, HEDIS 2007 Performance Measures

MO HealthNet Managed Care health plan	Annual Dental Visit	Adolescent Well-Care Visit	Follow-up After Hospitalization for Mental Illness
Blue-Advantage Plus of Kansas City	Substantially Compliant	Substantially Compliant	Substantially Compliant
Children's Mercy Family Health Partners	Substantially Compliant	Substantially Compliant	Substantially Compliant
Healthcare USA	Substantially Compliant	Substantially Compliant	Substantially Compliant
Mercy CarePlus	Substantially Compliant	Substantially Compliant	Fully Compliant
Missouri Care	Substantially Compliant	Fully Compliant	Substantially Compliant

Missouri Care reported a rate for the HEDIS 2007 Adolescent Well-Care Visits measure that was able to be fully validated by the EQRO, garnering a rating of Fully Compliant. Likewise, the HEDIS 2007 Follow-Up After Hospitalization for Mental Illness rates for Mercy CarePlus were Fully Compliant. Although all other ratings were not fully validated, each of them fell within the expected confidence intervals and therefore were determined to be Substantially Compliant.

3.5 Conclusions

In calculating the measures, MO HealthNet Managed Care health plans have adequate management information systems for capturing and storing enrollment, eligibility, and claims information for the calculation of the three HEDIS 2007 measures validated.

Among MO HealthNet Managed Care health plans there was good documentation of the HEDIS 2007 rate production process.

The rates of medical record submission for the one measure allowing the use of the Hybrid Methodology was superb, with all MO HealthNet Managed Care health plans submitting 100% of the records requested.

QUALITY OF CARE

The HEDIS 2007 Follow-Up After Hospitalization for Mental Illness measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care received by health plan members.

One MO HealthNet Managed Care health plan was Fully Compliant with the specifications for calculation of this measure. The four remaining MO HealthNet Managed Care health plans were substantially compliant with the specifications for calculation of this measure. (Harmony is not included in this evaluation as they were not a Missouri provider during the HEDIS 2007 measurement period.)

For the 7-day follow up rate, three MO HealthNet Managed Care health plans (BA+, CMFHP and MO Care) reported rates (58.67%, 48.50% and 42.58%, respectively) that were higher than the National Medicaid Average (39.1%) for this measure and one health plan (BA+) reported a rate higher than the National Commercial Average (56.7%).

The 7-Day reported rate for all MO HealthNet Managed Care health plans in 2007 (35.52%) was a 4.36% increase over the 7-day rate reported in 2006 (the last year this measure was audited by the EQR).

For the 30-day follow up rate, three MO HealthNet Managed Care health plans (BA+, CMFHP and MO Care) reported rates (76.00%, 88.37% and 63.16%, respectively) that were higher than the National Medicaid Average (57.7%) for this measure and two health plans (BA+ and CMFHP) reported rates higher than the National Commercial Average (75.0%).

The 30-Day reported rate for all MO HealthNet Managed Care health plans in 2007 (60.06%) was a 7.14% increase over the 30-day rate reported in 2006 (the last year this measure was audited by the EQR).

Due to the high rates reported for this measure it can be concluded that MO HealthNet Managed Care health plan members are receiving a higher quality of

care in the area of Follow-Up After Hospitalization for Mental Illness than other Medicaid recipients across the country.

ACCESS TO CARE

The HEDIS 2007 Annual Dental Visit measure is categorized as an Access/Availability of Service measure and is designated to measure the access to care received.

For the Annual Dental Visit measure, all five MC HealthNet Managed Care health plans reviewed were substantially compliant with the calculation of this measure.

The rate for All MO HealthNet Managed Care health plans of Annual Dental visits improved by 2.74% from the 2005 rate (the last year this measure was validated by the EQRO) of 29.76% to the 2007 rate of 32.50%. Thereby showing an increased level of dental care received in Missouri during the HEDIS 2007 measurement year.

For the Annual Dental Visit measure, none of the health plans reported a rate higher than the National Medicaid Average (42.5%).

TIMELINESS OF CARE

The HEDIS 2007 Adolescent Well Care Visits is categorized as a Use of Services measure and is designated to measure the timeliness of the care received. To increase the rate for both of these measures, age specific services must be delivered to members on a yearly basis.

For the Adolescent Well Care Visits measure, one health plan was fully compliant with the specifications for calculation of this measure and the remaining four were substantially compliant with the measure's calculation.

For the Adolescent Well Care Visits measure, two health plans (CMFHP and MO Care) reported rates (42.82% and 44.91%, respectively) higher than the National Commercial Average (40.3%) and one health plan (MO Care) reported a rate higher than the National Medicaid Rate (43.6%), as well.

The rate for All MO HealthNet Managed Care health plans improved by 4.68% from the 2004 reported rate of 30.13% for all health plans (the last year this measure was validated by the EQRO) to the 2007 rate for all health plans of 34.81%. Thereby showing an increased level of well care visits delivered to adolescents in Missouri during the HEDIS 2007 measurement year.

RECOMMENDATIONS

1. The SMA should consider requiring the Hybrid Method of calculation for some HEDIS measures. The two health plans who calculated the Adolescent Well Care Visits measure hybridly (CMFHP and MO Care) had the highest validated rates (42.82 % and 44.91%, respectively) and rates above both National benchmarks (National Commercial rate 40.3% and National Medicaid rate 43.6%).
2. MO HealthNet Managed Care health plans with significantly lower rates of eligible members (Annual Dental Visit (MCP), Adolescent Well Care Visits (CMFHP, MO Care) and Follow Up After Hospitalization for Mental Illness (HCUSA, MCP)) and administrative hits (Annual Dental Visit (MO Care), Adolescent Well Care Visits (MCP) and Follow UP After Hospitalization for Mental Illness (HCUSA, MCP)) should closely examine the potential reasons for fewer members and/or services identified. This may be due to member characteristics, but is more likely due to administration procedures and system characteristics such as the proportion of members receiving services from capitated providers. Identifying methods of improving administrative hits will improve the accuracy in calculating the measures.
3. The SMA should continue to have the EQRO validate the calculation of at least one measure from year to year, for comparison and analysis of trend data.
4. MO HealthNet Managed Care health plans should run query reports early enough in the HEDIS season so that they may effectuate change in rates where interventions could easily be employed.

4.0 VALIDATION OF ENCOUNTER DATA

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4.1 Definition

“For the purposes of this protocol, an encounter refers to the electronic record of a service provided to an MCO enrollee by both institutional and practitioner providers (regardless of how the provider was paid) when the service would traditionally be a billable service under Fee-for-Service (FFS) reimbursement systems.”¹²

An encounter is the unit of service provided to a Member by the health plan. Encounter data provides the same type of information found on a claim form. It does not substitute for medical record documentation, but should be consistent with and supported by medical record documentation (e.g. date of procedure, type of procedure). The MO HealthNet Managed Care health plans’ contract with the State Medicaid Agency (SMA; Missouri Department of Social Services, MO HealthNet Division; MHD) details the requirements for an acceptable submission of an encounter. The SMA’s requirements for encounter data submitted by the MO HealthNet Managed Care health plans include the type of encounter data and required data fields.

4.2 Purpose and Objectives

“Encounter data can be used to assess and improve quality, as well as monitor program integrity and determine capitation payment rates. However, in order for encounter data to effectively serve these purposes, it must be valid; i.e., complete and accurate...This protocol specifies processes for assessing the completeness and accuracy of encounter data submitted by MCOs and PIHPs to the State. It also can assist in the improvement of the processes associated with the collection and submission of encounter data to State Medicaid agencies.”¹³

¹² Department of Health and Human Services. Centers for Medicare and Medicaid Services (2002). Validating Encounter Data: A protocol for use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0, May 1, 2002. Washington, D.C.: Author.

¹³ Ibid.

Three objectives for the encounter validation were identified. They included: assessing the quality of data for required fields for each claim type; evaluating the representativeness (or completeness) of the SMA encounter claims database for MO HealthNet Managed Care health plan paid and unpaid claims; and validating medical records against the SMA encounter claims database. The following were the objectives and associated evaluation questions.

1. The first objective was to obtain a quality baseline of the SMA encounter claim database (completeness, accuracy, and reasonableness). The alternative hypothesis was that all data fields in the SMA encounter claims database consist of valid (complete, accurate, and reasonable) encounter claim data. Appendix 6 shows the recommended minimum criteria established for completeness and accuracy of specific data fields. Several evaluation questions were addressed:
 - What is the baseline level of completeness, accuracy, and reasonableness of the critical fields?
 - What is the level of volume and consistency of services?
 - What are the data quality issues associated with the processing of encounter data?
 - What problems are there with how files are compiled and submitted by the health plan?
 - What types of encounter claim data are missing and why?
2. The second objective was to examine the match between MO HealthNet Managed Care health plan claims (paid and unpaid) and the SMA encounter paid claims database. This would facilitate identification of the level of completeness of the SMA encounter claims database as represented by MO HealthNet Managed Care health plans paid claims. The alternative hypotheses were that 100% of MO HealthNet Managed Care health plans paid claims are represented in the SMA encounter claims database, and 0.00% of MO HealthNet Managed Care health plans unpaid claims are represented in the SMA encounter claims database. Several evaluation questions were posed:
 - What types of paid encounter data are missing and why?
 - What is the fault/match rate of paid and unpaid encounter claims in the SMA encounter claim database and the MO HealthNet Managed Care health plans claims database?
 - What services are being provided that are not being paid?
 - How many services are being provided that are not being paid?
3. The third objective was to validate the SMA encounter claims (paid) database against medical record documentation and obtain a baseline fault (error) rate for the level of accuracy of the SMA encounter claims database relative to the services delivered by MO HealthNet Managed Care health plan providers. The alternative hypothesis was that there is a 100% match between the encounter claim data in the medical record and the

data in the SMA encounter claims database. Accuracy or match rates of 70% or greater are anticipated for new Medicaid managed care organizations¹⁴. Several evaluation questions were addressed:

- To what extent do the claims in the SMA encounter claims database reflect the information documented in the medical record?
- What is the fault/match rate between SMA encounter claims and medical records?
- What types of errors are noted?

¹⁴ Medstat (1999). A Guide for States to Assist in the Collection and Analysis of Medicaid Managed Care Data: Second Edition.

4.3 Technical Methods

TIME FRAME

The dates of service from July 1, 2007 through September 30, 2007 were selected by the SMA for the three encounter data validation objectives.

PROCEDURES FOR DATA COLLECTION

For the first objective, the SMA encounter claims extract file was used to examine the completeness, accuracy, and reasonableness of the critical fields and to calculate the rate of each claim type per 1,000 members by MO HealthNet Managed Care health plans. There are six claim types described in the SMA Health Plan Layout Manual: I = Inpatient claim type; M = Medical claim type; O = Outpatient Hospital claim type; D = Dental claim type; H = Home Health claim type; and P = Pharmacy claim type. Inpatient, Outpatient and Home Health claim types are submitted using a Universal Billing (UB-92) file layout, Medical and Dental claim types are submitted using a National Standard Format/Centers for Medicare and Medicaid Services 1500 (NSF/CMS 1500) file layout, and the Pharmacy claims are submitted using the National Council for Prescription Drug Programs, version 3 file layout (NCPDP v.3.0). All claims are sent from the MO HealthNet Managed Care health plans to the SMA through the SMA claims vendor, InfoCrossing, and claim types are assigned by the Medicaid Management Information System (MMIS).

After review and approval of the technical methods and objectives by the SMA, the EQRO reviewed, discussed with the SMA, and submitted a data request (see Appendix 7) for the SMA encounter claims extract file to be validated for each claim type and each MO HealthNet Managed Care health plan. The file request was made to the SMA on January 9, 2008 and received on February 29, 2008 by the EQRO. The SMA reviewed and approved the data request and parameters for the designated fields to be validated by the EQRO.

For the second objective of comparing the SMA encounter claims with MO HealthNet Managed Care health plans' paid and unpaid claims, the SMA encounter claims extract file was parsed by type of file layout (NSF/CMS 1500, UB-92, or NCPDP v.3.0) in preparation for matching against MO HealthNet Managed Care health plan paid and unpaid claims. A cross-walk for matching MMIS field names with those of the three national standards file layouts was developed and submitted to the SMA for review (February 8, 2005) and approval (March 29, 2005). MO HealthNet Managed Care health plans were requested to provide paid and unpaid claims for the designated period on the sample of members selected by the EQRO. While last year all six MO HealthNet Managed Care health plans supplied the appropriate information required, this year, only five of the six health plans submitted the requested information.

The number of Medical encounter claims in the SMA encounter claims extract file was used for sample size estimation for the third objective and analysis of the evaluation questions. To examine the degree of match between the SMA encounter claims database and medical record procedures and diagnoses, 100 encounters from each MO HealthNet Managed Care health plan were randomly selected from Medical claim types for the period of July 1, 2007 through September 30, 2007 for medical record review. Appendix 8, Appendix 9, and Appendix 10 contain letters of request to providers for medical records, the Table of Contents for the Medical Record Review Training Manual, and copies of medical record review tools. Several challenges in requesting the data were addressed.

ANALYSES

To assess the accuracy and completeness of the SMA encounter claims database, the SMA encounter claims extract file for all MO HealthNet Managed Care health plan paid encounter claims representing services rendered from July 1, 2007 through September 30, 2007 was analyzed for completeness, accuracy, and reasonableness (validity) of the data in each "critical", or required field examined. The Inpatient, Medical, Dental, Home Health, Outpatient Hospital, Pharmacy, and critical fields

were chosen by the SMA for analysis, with an established threshold of 100% for completion, accuracy, and validity:



Medical (NSF/CMS 1500) Claim Type

Outpatient Claim Type
 Recipient ID
 First Date of Service
 Last Date of Service
 Place of Service
 Units of Service
 Procedure Code
 Inpatient Diagnosis (five diagnosis fields)

Dental (NSF/CMS 1500) Claim Type

Outpatient Claim Type
 Recipient ID
 First Date of Service
 Last Date of Service
 Units of Service
 Procedure Code

Home Health (UB-92) Claim Type

Outpatient Claim Type
 Recipient ID
 First Date of Service
 Last Date of Service
 Units of Service
 Procedure Code
 Revenue Code
 Inpatient Diagnosis (five diagnosis fields)

Inpatient (UB-92) Claim Type

Inpatient Claim Type

Recipient ID
 Admission Type
 Admission Date
 Discharge Date
 Bill Type
 Patient Discharge Status
 Inpatient Diagnosis (five diagnosis fields)
 First Date of Billing
 Last Date of Billing
 Revenue Code
 Units of Service

Outpatient Hospital (UB-92) Claim Type

Outpatient Claim Type
 Recipient ID
 First Date of Service
 Last Date of Service
 Place of Service
 Units of Service
 Procedure Code
 Inpatient Diagnosis (five diagnosis fields)

Pharmacy (NCPDP v.3.0)

Recipient ID
 Dispensing Date
 Pharmacy Prescription Number
 Drug Quantity Dispensed
 Number of Days Supply
 National Drug Code

Each field was examined for the presence or absence of data (completeness), the correct type and size of information (accuracy), and the presence of valid values (reasonableness) or validity using the criteria listed below.

Completeness:	The extent to which an encounter claim field contains data (either present or absent).
Accuracy:	The extent to which an encounter claim field contains the correct type of information (e.g., numeric, alpha, alphanumeric) in the proper format (e.g., mm/dd/yyyy for date field).
Reasonableness (Validity):	The extent to which an encounter claim field represents a valid value (e.g., an actual procedure code, actual birth date)

For the validation of the SMA encounter claims extract file with MO HealthNet Managed Care health plan medical records, the goal was to validate the procedure code and diagnosis code fields for the Outpatient claim types in the SMA encounter claims database against the information provided in the medical record. The minimum number of records required for the evaluation of two variables (procedure and diagnosis code) with an estimated error rate of 30% (based on

Medstat estimates¹⁵), reliability of 1.96 (95% statistical significance), and a meaningful difference of 55% were calculated using the number of Medical encounters in the SMA encounter claims file for each MO HealthNet Managed Care health plan (see Figure 14). There were no differences in the number of required records for MO HealthNet Managed Care health plans, with the minimum required sample size of 88. A total of 100 encounters for each MO HealthNet Managed Care health plan were randomly selected for medical record review using a probability sample.

Figure 14 - Formula for Calculating Minimum Required Sample Size

$$n = \frac{z^2 N P_y (1 - P_y)}{(N - 1) \epsilon^2 P_y^2 + z^2 P_y (1 - P_y)}$$

Where P_y = Estimated True Error Rate; meaningful difference between true and estimated value ; z = level of reliability; $\epsilon = 1/(P_y - \text{meaningful difference})/\text{meaningful difference}$; N = number of Medicaid Claim Types for the period January 1, 2004-March 31, 2004; n = Minimum required sample size¹⁶

4.4 Findings

One limitation of the present analysis is that the encounter claim completeness and accuracy analysis was based on paid encounter claims and does not account for all claims that are submitted and rejected through system edits. Also, because the SMA encounter claims extract file was for service dates from July 1, 2007 through September 30, 2007, some service dates might extend beyond this period. For example, if the first date of service was later in the period (e.g., September 30, 2007), the last date of service may extend beyond the period specified by SMA parameters for the validation process (e.g., a Discharge Date of October 1, 2007). When last dates of service appeared to be within a reasonable period, dates outside the valid range were considered valid. In addition, the second through fifth

¹⁵ Medstat (1999). A Guide for States to Assist in the Collection and Analysis of Medicaid Managed Care Data: Second Edition.

¹⁶ Levy, P.S. & Lemeshow, S. L. (1999). Sampling of Populations: Methods and Applications, Third Edition, John Wiley and Sons: New York; see box 3.5 for Exact and approximate sample sizes required under simple random sampling for proportions.

diagnosis code fields are required when the information is available. Not all encounters had five diagnoses. Therefore, 100.00% completion of these fields would not be expected. Conclusions regarding the extent to which the encounter claims database reflects the accuracy and completeness of rejected claims cannot be drawn. Thereby, the information contained in this aggregate section is available at the MO HealthNet Managed Care health plan level in the individual MO HealthNet Managed Care health plan summaries. The findings of the encounter data validation are presented in response to each evaluation question, by claim type and critical field for all MO HealthNet Managed Care health plans.

What is the Baseline Level of Completeness, Accuracy, and Reasonableness of the Critical fields?

For the Medical claim type, there were a total of 961,822 encounter claims paid by the SMA for the period July 1, 2007 through September 30, 2007.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Outpatient Recipient ID field was 100.00% complete, accurate and valid.
3. The Outpatient First Date of Service field was 100.00% complete, accurate and valid.
4. The Outpatient Last Date of Service field was 100.00% complete, accurate and valid.
5. The Outpatient Units of Service field was 100.00% complete, accurate, and valid.
6. The Outpatient Procedure Code field was 100.00% complete, accurate, and 99.99% valid (6 fields contained invalid codes).
7. The Outpatient Place of Service field was 100.00% complete, accurate and valid.
8. The first, Diagnosis Code fields were 100.00% complete, accurate and valid.
9. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, they all fell well below the 100% threshold established by the SMA for this validation. The second Diagnosis Code field was 28.44% complete, accurate and valid. The remaining fields (n = 688,217) were blank. The third Diagnosis Code field was 11.32% complete, accurate and valid. The remaining fields (n= 852,994) were blank (incomplete, inaccurate, and invalid). The fourth diagnosis code field was 5.37% complete, accurate and valid. The remaining fields (n = 910,126) were blank (incomplete, inaccurate, and invalid). The fifth Diagnosis Code field was 0.01% complete and accurate. The remaining fields (n=961,702) were blank. The fifth Diagnosis Code field was 0.0% valid with 961,702 fields blank and 120 fields containing the invalid code.XO1.

For the Dental claim type, there were 134,974 encounter claims paid by the SMA for the period July 1, 2007 through September 30, 2007. All critical fields examined were

100.00% complete, accurate and valid for all MO HealthNet Managed Care health plans.

For the Home Health claim type, there were a total of 235 encounter claims paid by the SMA for the period July 1, 2007 through September 30, 2007.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Recipient ID field was 100.00% complete, accurate and valid.
3. The First Date of Service field was 100.00% complete, accurate and valid.
4. The Last Date of Service field was 100.00% complete, accurate and valid.
5. The Units of Service field was 100.00% complete, accurate and valid.
6. The Procedure Code field was 79.57% complete, accurate and valid. The remaining fields (n = 48) were blank (incomplete, inaccurate, and invalid).
7. The first, Diagnosis Code field was 100.00% complete, accurate and valid.
8. The second Diagnosis Code field was 28.09% complete, accurate and valid. The remaining fields (n= 169) were blank (incomplete, inaccurate, and invalid).
9. The third Diagnosis Code field was 20.0% complete, accurate and valid. The remaining fields (n=188) were blank (incomplete, inaccurate, and invalid).
10. The fourth Diagnosis Code field was 6.38% complete, accurate and valid. The remaining fields (n = 220) were blank (incomplete, inaccurate, and invalid).
11. The fifth Diagnosis Code field was 2.56% complete, accurate and valid. The remaining fields (n = 229) were blank (incomplete, inaccurate, and invalid).

For the Inpatient claim type, there were a total of 102,232 encounter claims paid by the SMA for the period July 1, 2007 through September 30, 2007.

1. The Inpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Recipient ID field was 100.00% complete, accurate and valid.
3. The Admission Type field was 100.00% complete, accurate, and valid.
4. The Admission Date field was 100.00% complete and 99.99% accurate, and valid. Invalid entries of 11/13/06, 12/29/06 and 01/11/07 were present in 127 fields.
5. The Discharge Date field was 100.00% complete and 97.80% accurate and valid. Invalid entries of "99999999" were present in 2244 fields.
6. The Bill Type field was 100.00% complete, accurate and valid.
7. The Patient Status field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 100.00% complete, accurate and 99.99% valid. The remaining fields (n = 77) were blank (incomplete, inaccurate, and invalid).
9. The second, third, fourth, and fifth Diagnosis Code fields fell below the 100% threshold for completeness, accuracy, and validity established by the SMA (95.95%, 79.91%, 70.83%, and 56.19%, respectively). The remaining fields were blank (incomplete, inaccurate, and invalid) or contained invalid code: X01.
10. The First Date of Billing field was 100.00% complete, accurate and valid.
11. The Last Date of Billing field was 100.00% complete, accurate and valid.

12. The Revenue Code field was 100% complete, accurate, and valid.
13. The Units of Service field was 100.00% complete, accurate and valid.

For the Outpatient Hospital claim type, there were a total of 477,101 encounter claims paid by the SMA for the period July 1, 2007 through September 30, 2007.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Recipient ID field was 100.00% complete, accurate and valid.
3. The First Date of Service field was 100.00% complete and accurate, and valid.
4. The Last Date of Service field was 100.00% complete and accurate, and valid.
5. The Units of Service field was 100.00% complete, accurate and valid.
6. The Outpatient Procedure Code field was 99.13% complete and accurate. The remaining fields were blank (incomplete, inaccurate, and invalid). The fields were 63.12% valid. There were 148,572 fields containing "00000" and 23,210 containing invalid codes.
7. The Outpatient Revenue Code field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 100.00% complete, accurate and valid.
9. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, they all fell well below the 100% threshold established by the SMA for this validation. . The Diagnosis Code fields were 77.41%, 59.66%, 31.26% and 15.52% complete, accurate and valid (incomplete, inaccurate, and invalid). The remaining fields were blank (n= 107,758; 192,463; 327,964; 403,034 respectively) (incomplete, inaccurate, and invalid) or contained the invalid code X01 (n= 30).

For the Pharmacy claim type, there were 450,070 claims paid by the SMA for the period July 1, 2007 through September 30, 2007. All fields examined were 100.00% complete, accurate and valid (Recipient ID, First Date of Service, Prescription Number, Quantity Dispensed, Days Supply, and National Drug Code).

What is the Level of Volume and Consistency of Services?

One method of examining the level, consistency, and volume of services is to assess the extent to which each MO HealthNet Managed Care health plan is consistent with the remaining MO HealthNet Managed Care health plans and the average of all MO HealthNet Managed Care health plans services represented in the SMA encounter claims database. The level, consistency, and volume of services represented in the SMA encounter claims database is a function of the acceptance of encounter claim submissions. It is also a function of the process of manipulation of data from national standard layouts for Medical (NSF/CMS 1500); Dental (NSF/CMS 1500); Inpatient, Outpatient Hospital, Home Health (UB-92); and Pharmacy claims (NCPDP 3.0) into the State MMIS system edits. Additionally, the entry and

transmission of data by MO HealthNet Managed Care health plans, vendors, and providers, the accessibility of services, member utilization patterns, and provider practice patterns influence the data. With the large number of members enrolled in each MO HealthNet Managed Care health plan, it was expected that factors such as physician practice patterns and member utilization patterns would not have a statistically significant impact on the findings, resulting in all MO HealthNet Managed Care health plans having similar rates of encounters per 1,000 members as the rate for all MO HealthNet Managed Care health plans. Statistically significant findings are more likely a function of the data quality and completeness resulting from the processing of data by providers, vendors, MO HealthNet Managed Care health plans, and the MMIS rather than the accessibility or quality of services.

Another method of examining the level, consistency, and volume of services is to compare the baseline per 1,000 member encounter data collected during the 2006 EQRO audit to the data obtained during this audit. By comparing service levels received during the July 1, 2006 – September 30, 2006 with the service levels reported during the time July 1, 2007 – September 30, 2007, a comparison of accessibility to services and member utilization patterns can be made.

Using the SMA encounter claims extract files from July 1, 2006 through September 30, 2006, and July 1, 2007 through September 30, 2007 the volume of services for each claim type and MO HealthNet Managed Care health plan was examined. The rate of each claim type, regardless of the accuracy, consistency, and validity of the data was examined. The rate of claims per 1,000 members based on one quarter of data was calculated by dividing the number of members enrolled as of the last week of September for each year, by 4, then calculating the rate of claims per 1,000 members. Figure 15 through Figure 26 illustrate the rates of claim types and the results of two-tailed z-tests comparing each MO HealthNet Managed Care health plan with the statewide rate of claims. Statistically significant differences between an MO HealthNet Managed Care health plan and the rate for all MO HealthNet Managed Care health plans at the 95% level of statistical significance are indicated by an asterisk. The 95% upper and lower confidence limits are

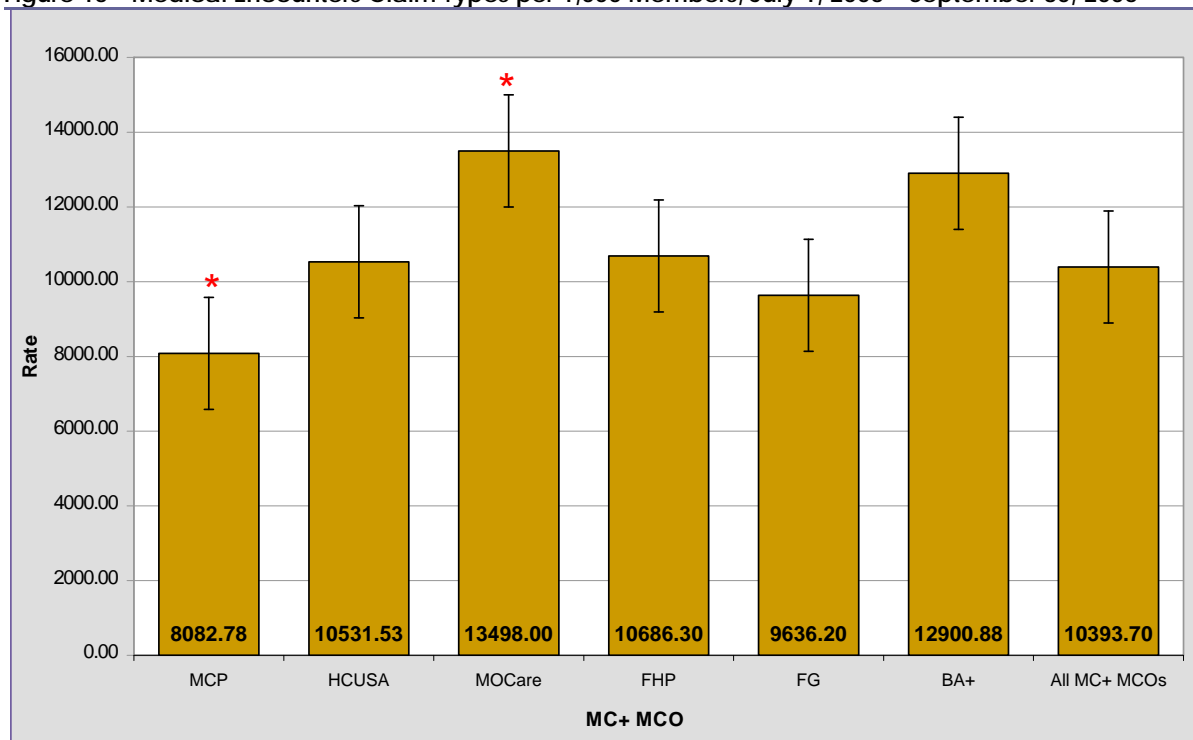
represented by the black bars on the y-axis. For comparisons that were statistically significant at the 95% confidence interval (CI), the z-score (z), the upper and lower confidence intervals (CI), and the significance levels ($p < .05$) are reported. When there was no statistical significance, the significance level is reported as "not significant" (n.s.).

Medical encounter claim types consist of claims submitted by providers, vendors, and MO HealthNet Managed Care health plans.

The results for the 2006 EQR audit were similar to those reported in 2007. In 2006, the rate for all MO HealthNet Managed Care health plans was 10,393.70 Medical encounter claims per 1,000 members (see Figure 15). In 2006, Missouri Care showed a significantly higher rate, while Mercy CarePlus had a significantly lower rate of Medical encounter claims than the rate for all MO HealthNet Managed Care health plans.

For 2007, as shown in Figure 15, there was some variability across MO HealthNet Managed Care health plans in the statewide rate per 1,000 members of Medical encounter claim types compared to the rate for all MO HealthNet Managed Care health plans (11,184.84 Medical encounter claims per 1,000 members). One MO HealthNet Managed Care health plan (HealthCare USA, 13168.60, $z = 0.833$; 95% CI: 9717.69, 16619.51; $p < .01$) showed a significantly higher rate, while one MO HealthNet Managed Care health plan (Harmony 928.49, $z = -1.79$; 95% CI: -2522.42, 4379.40; $p < .01$) had a significantly lower rate of Medical Encounter claims than the rate for all MO HealthNet Managed Care health plans.

Figure 15 - Medical Encounters Claim Types per 1,000 Members, July 1, 2006 – September 30, 2006

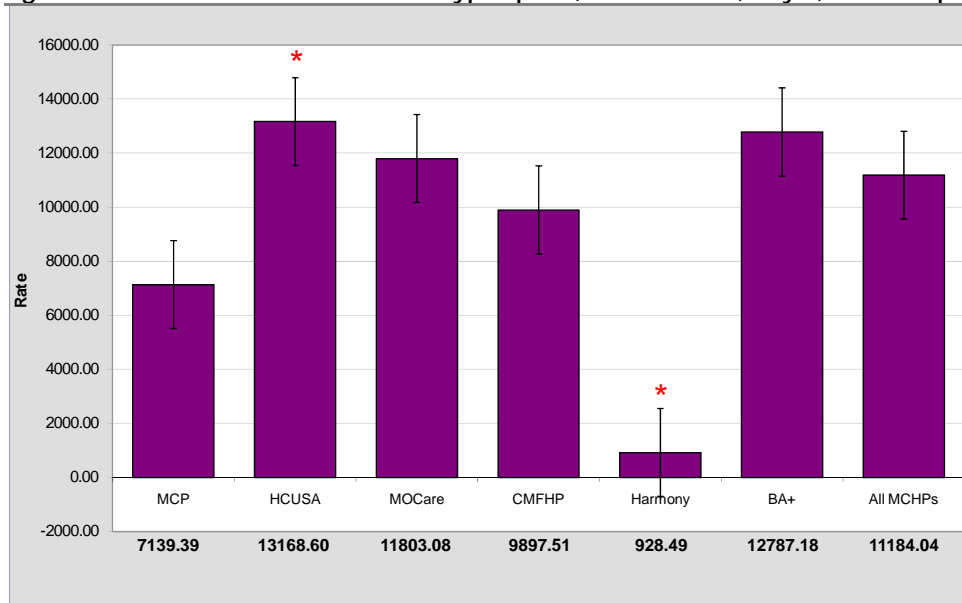


Note: Rate per 1,000 members is an estimated annual rate based on first quarter state encounter data;

Rate per 1,000 members = Number Claims July1-2006 – September 30, 2006 / (Number members / 4) X 1,000. Enrollment as of the last week of September 2006 was used to calculate the rate per 1,000 members. Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.

Source: Missouri Department of Social Services, MO HealthNet Division, State Session MPRI screen, enrollment for all Waivers.

Figure 16 - Medical Encounters Claim Types per 1,000 Members, July 1, 2007 – September 30, 2007



Note: Rate per 1,000 members is an estimated annual rate based on first quarter state encounter data; Rate per 1,000 members = Number Claims July1-2007 – September 30, 2007 / (Number members / 4) X 1,000. Enrollment as of the last week of September 2007 was used to calculate the rate per 1,000 members. Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.

Source: Missouri Department of Social Services, MO HealthNet Division, State Session MPRI screen, enrollment for all Waivers.

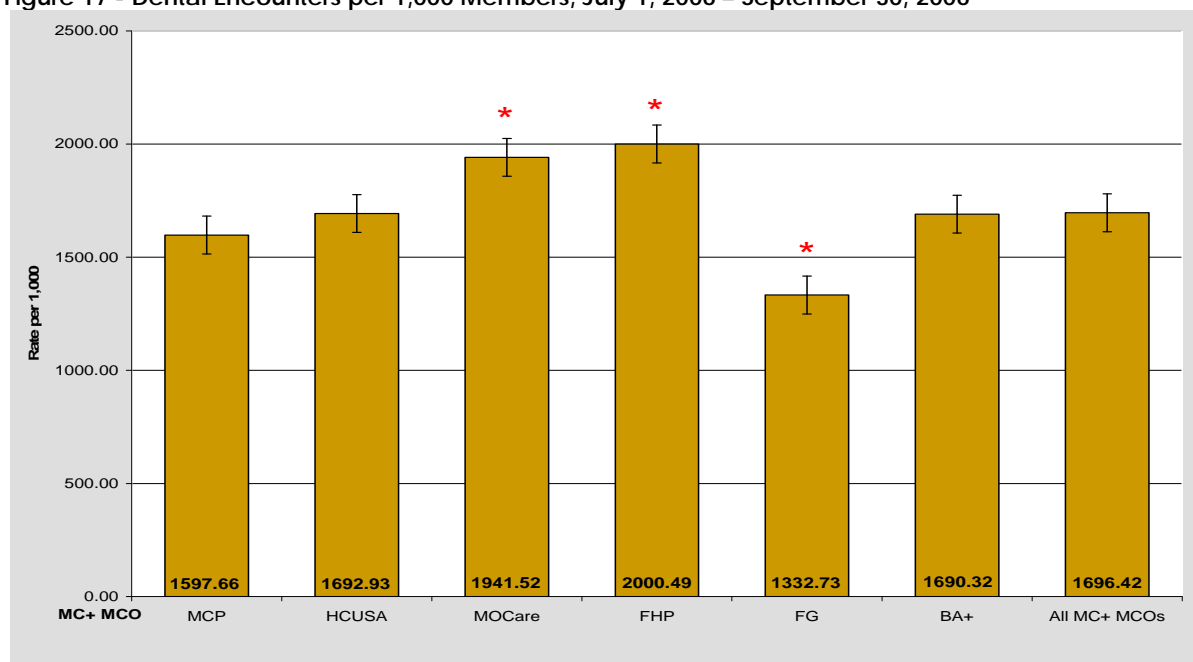
Dental encounter claims consist of claims submitted by providers, vendors, and MO HealthNet Managed Care health plans.

In 2006, as shown in Figure 17, there was some variability across MO HealthNet Managed Care health plans in the rate per 1,000 members of Dental encounter claims compared to the rate for all MO HealthNet Managed Care health plans (1696.42 Dental encounter claims per 1,000 members) submitted in 2006. Two MO HealthNet Managed Care health plans (Children's Mercy Family Health Partners, 2000.49, $z = 1.20$; 95% CI: 1820.97, 2180.01; $p < .05$) and (Missouri Care, 1941.52, $z =$

0.96; 95% CI: 1762.00, 2121.04; $p < .05$) had significantly higher rates than the average for all MO HealthNet health plans. While one health plan (FirstGuard, 1332.73, $z = -1.55$; 95% CI: 1153.21, 1512.25; $p < .05$) had significantly lower rates of Dental encounter claims per 1,000 members than the rate for all MO HealthNet Managed Care health plans.

In 2007, there was a higher rate for all MO HealthNet Managed Care health plans of Dental encounter claims (1569.47 Dental encounter claims per 1,000 members) than in 2006 (see Figure 18). One MO HealthNet Managed Care health plan (Children's Mercy Family Health Partners, 1819.80, $z = .84$; 95% CI: 1334.04, 2305.56538.40; $p < .05$) had a significantly higher rate. While one MO HealthNet Managed Care health plan (Harmony Health Plan, 000.00, $z = -1.94$; 95% CI: -485.76, 485.76; $p < .05$) had a significantly lower rate of Dental encounter claims per 1,000 members than the rate for all MO HealthNet Managed Care health plans.

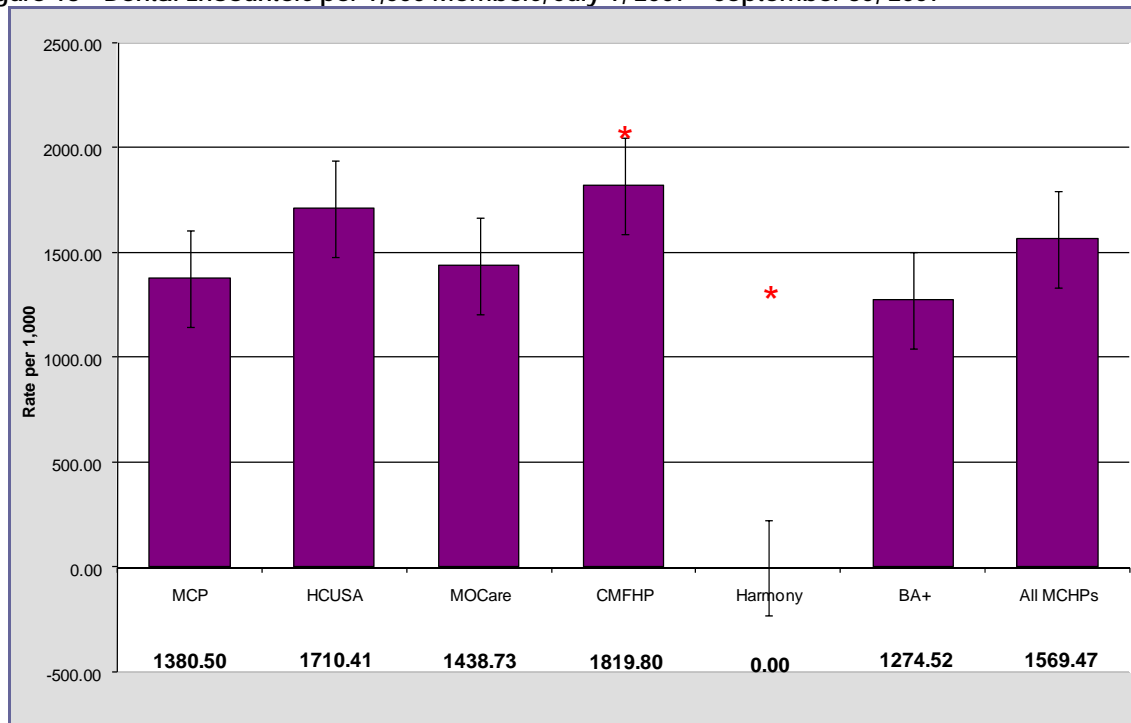
Figure 17 - Dental Encounters per 1,000 Members, July 1, 2006 – September 30, 2006



Note: Rate per 1,000 members is an estimated annual rate based on first quarter state encounter data; Rate per 1,000 members = Number Claims July 1-2006 – September 30, 2006 / (Number members / 4) X 1,000. Enrollment as of the last week of September 2006 was used to calculate the rate per 1,000 members. Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.

Source: Missouri Department of Social Services, MO HealthNet Division, State Session MPRI screen, enrollment for all Waivers.

Figure 18 - Dental Encounters per 1,000 Members, July 1, 2007 – September 30, 2007



Note: Rate per 1,000 members is an estimated annual rate based on first quarter state encounter data; Rate per 1,000 members = Number Claims July 1-2007 – September 30, 2007 / (Number members / 4) X 1,000. Enrollment as of the last week of September 2007 was used to calculate the rate per 1,000 members. Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.

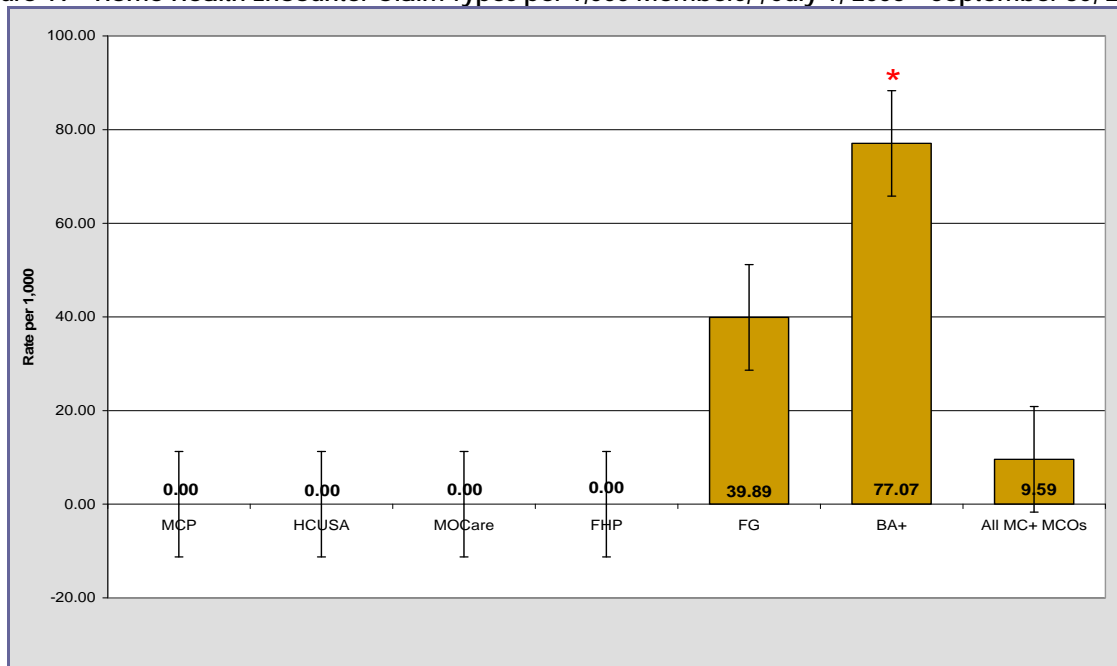
Source: Missouri Department of Social Services, MO HealthNet Division, State Session MPRI screen, enrollment for all Waivers.

In 2006, there were very few Home Health encounter claim types submitted by MO HealthNet Managed Care health plans. Only two of the six MO HealthNet Managed Care health plans submitted Home Health encounters, see Figure 19. Therefore, those two health plans (FirstGuard, 39.89, $z = 0.63$; 95% CI: 15.88, 63.90; $p < .05$ and Blue-Advantage Plus of Kansas City, 77.07, $z = 1.78$; 95% CI: 53.06, 101.08; $p < .05$) submitted significantly higher rates of Home Health encounter claims than the rate for all MO HealthNet Managed Care health plans (9.59 Home Health encounter claims per 1,000 members) .

In 2007, again only two of the six health plans submitted Home Health encounters, see Figure 20. However, only one of these health plans (BA+, 35.02, $z = 2.04$; 95% CI: 24.43, 45.61; $p = 0.00$) submitted a significantly higher rate of Home Health

encounter claims than the rate for all MO HealthNet Managed Care health plans (2.73 Home Health encounter claims per 1,000 members).

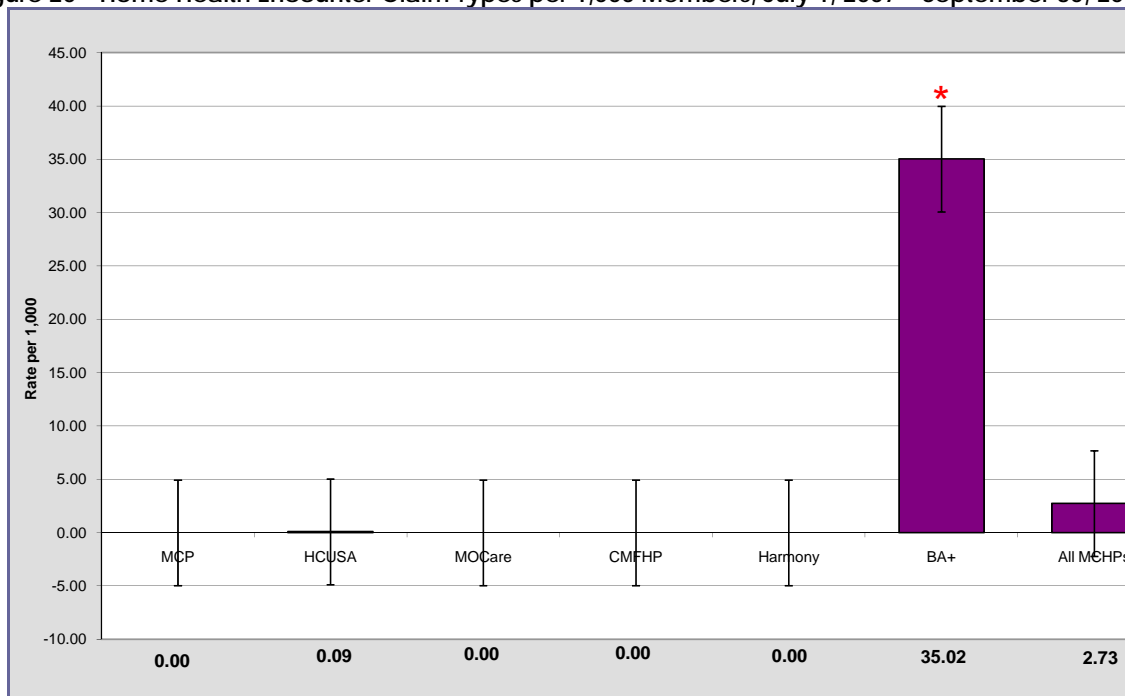
Figure 19 - Home Health Encounter Claim Types per 1,000 Members, , July 1, 2006 – September 30, 2006



Note: Rate per 1,000 members is an estimated annual rate based on first quarter state encounter data; Rate per 1,000 members = Number Claims July 1-2006 – September 30, 2006 / (Number members / 4) X 1,000. Enrollment as of the last week of September 2006 was used to calculate the rate per 1,000 members. Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.

Source: MO Dept of Social Services, Division of Medical Services, State Session MPRI screen, enrollment for all Waivers.

Figure 20 - Home Health Encounter Claim Types per 1,000 Members, July 1, 2007 – September 30, 2007



Note: Rate per 1,000 members is an estimated annual rate based on first quarter state encounter data; Rate per 1,000 members = Number Claims July 1-2007 – September 30, 2007 / (Number members / 4) X

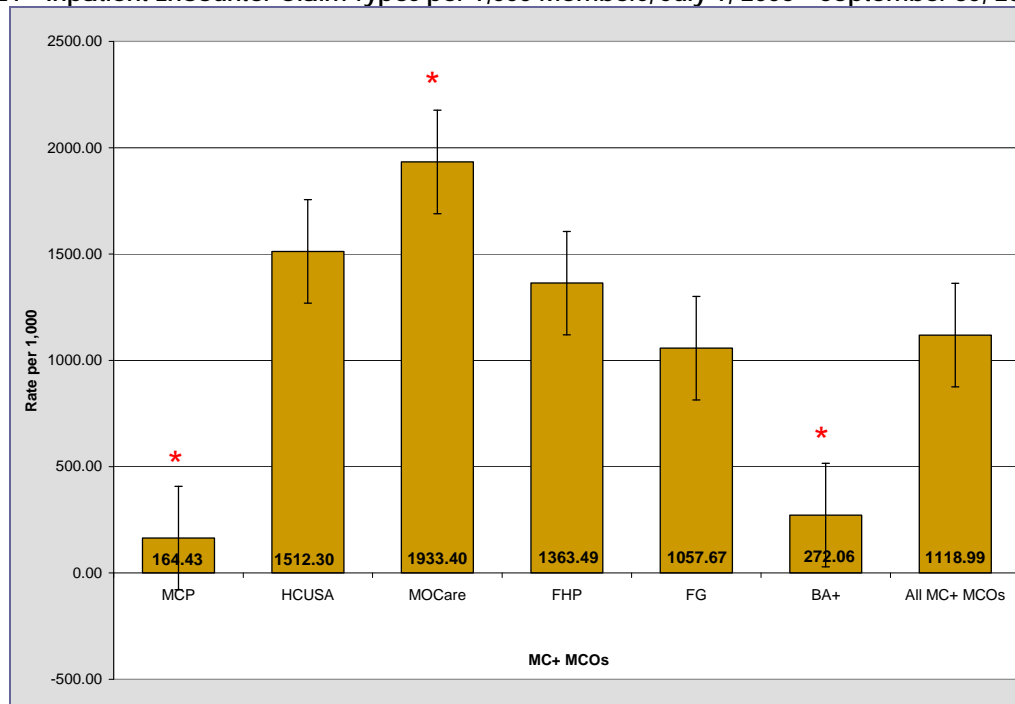
1,000. Enrollment as of the last week of September 2007 was used to calculate the rate per 1,000 members. Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.

Source: MO Dept of Social Services, Division of Medical Services, State Session MPRI screen, enrollment for all Waivers

Inpatient encounter claim types consist of claims submitted by hospital facilities and MO HealthNet Managed Care health plans. As shown in Figure 21, in 2006, there was some variability across MO HealthNet Managed Care health plans in the rate per 1,000 members of Inpatient encounter claims compared to the rate for all MO HealthNet Managed Care health plans (1118.99 Inpatient encounter claims per 1,000 members). One MO HealthNet Managed Care health plan had significantly higher rates of Inpatient encounter claims (Missouri Care, 1933.40, $z = 1.25$; 95% CI: 1411.47, 2455.33, $p < .01$). Two MO HealthNet Managed Care health plans had significantly lower rates of Inpatient encounter claims (MercyCare Plus, 164.43, $z = -1.26$; 95% CI: -357.50, 686.36; $p < .01$; Blue-Advantage Plus of Kansas City, 272.06, $z = -1.11$; 95% CI: -249.87, 793.99; $p < .01$) than the rate for all MO HealthNet Managed Care health plans.

In 2007, the EQRO found that two MO HealthNet Managed Care health plans had significantly lower rates of Inpatient encounter claims (Harmony, 0.00, $z = -1.36$; 95% CI: -558.98, 558.98; $p < .01$; MercyCare Plus, 157.47, $z = -1.15$; 95% CI: -401.51, 716.45; $p < .01$). One health plan had a significantly higher rate of Inpatient encounter claims (BlueAdvantage Plus of Kansas City, 1755.65, $z = 0.97$; 95% CI: 1196.67, 2314.63; $p < .05$) compared to the rate for all MO HealthNet Managed Care health plans.

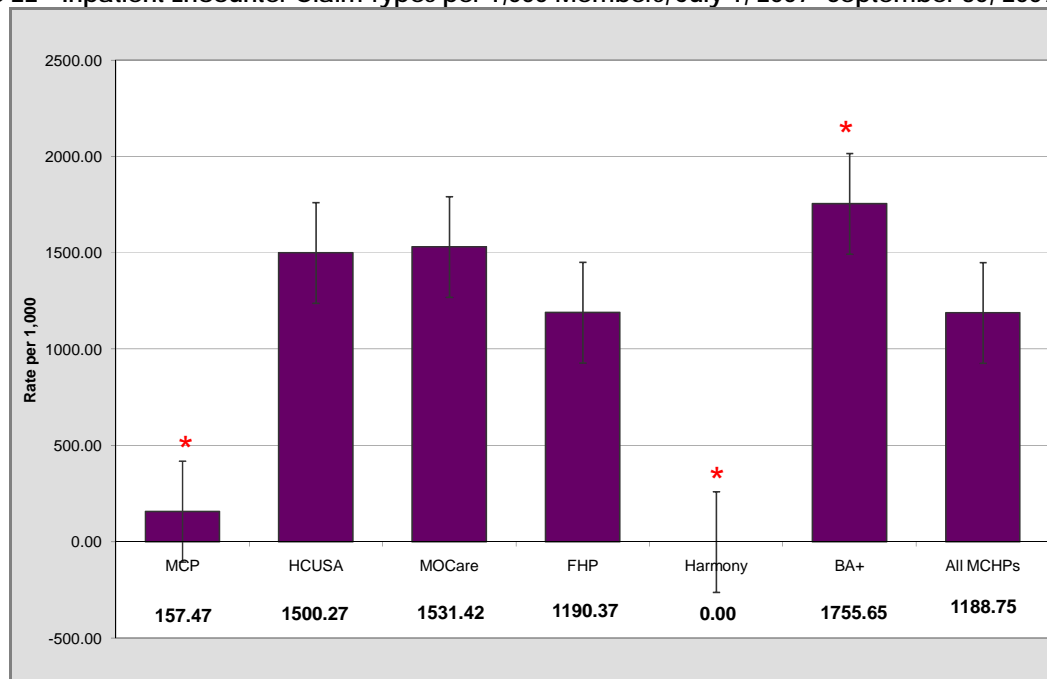
Figure 21 - Inpatient Encounter Claim Types per 1,000 Members, July 1, 2006 – September 30, 2006



Note: Rate per 1,000 members is an estimated annual rate based on first quarter state encounter data; Rate per 1,000 members = Number Claims July1-2006 – September 30, 2006 / (Number members / 4) X 1,000. Enrollment as of the last week of September 2006 was used to calculate the rate per 1,000 members. Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.

Source: Missouri Department of Social Services, Division of Medical Services, State Session MPRI screen, enrollment for all Waivers.

Figure 22 - Inpatient Encounter Claim Types per 1,000 Members, July 1, 2007- September 30, 2007



Note: Rate per 1,000 members is an estimated annual rate based on first quarter state encounter data; Rate per 1,000 members = Number Claims July1-2007 – September 30, 2007 / (Number members / 4) X 1,000. Enrollment as of

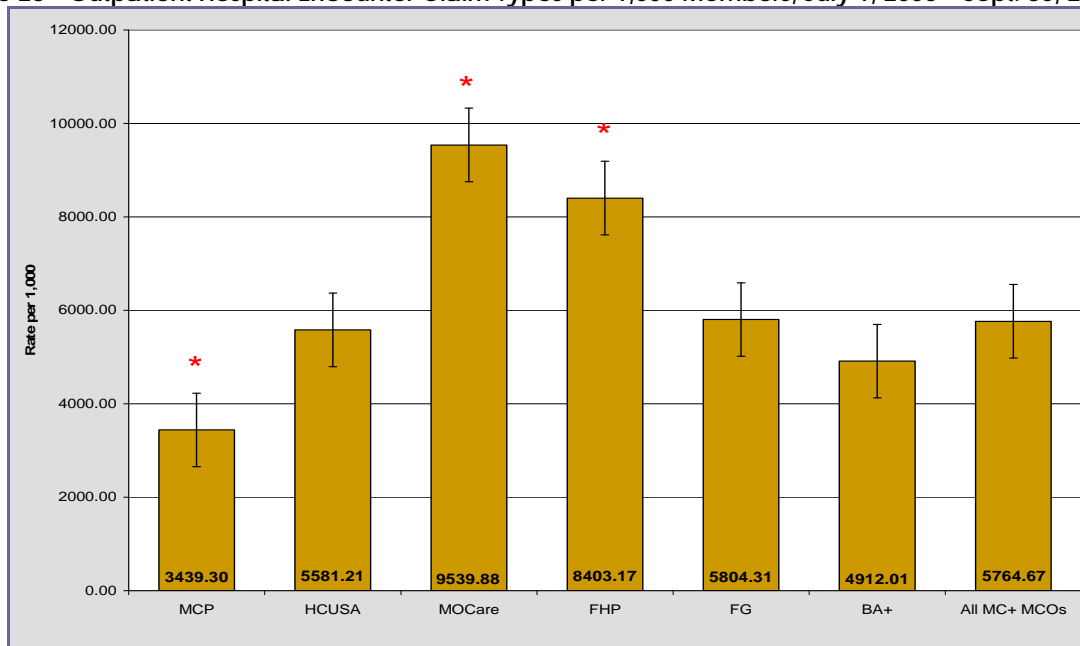
the last week of September 2007 was used to calculate the rate per 1,000 members. Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.

Source: Missouri Department of Social Services, Division of Medical Services, State Session MPRI screen, enrollment for all Waivers.

Outpatient Hospital encounter claim types consist of claims submitted by outpatient hospital facilities and MO HealthNet Managed Care health plans. As shown in Figure 23, in 2006, there was some variability across MO HealthNet Managed Care health plans compared to the rate for all MO HealthNet Managed Care health plans (5,764.67 Outpatient Hospital encounter claims per 1,000 members). Two MO HealthNet Managed Care health plans had significantly higher rates of Inpatient encounter claims (Missouri Care, 9539.88, $z = 1.44$; 95% CI: 7857.40, 11222.36; $p < .05$; Family Health Partners, 8403.17, $z = 0.93$; 95% CI: 6720.69, 10085.65; $p < .05$). While one MO HealthNet Managed Care health plan had significantly lower rates of Outpatient Hospital encounter claims per 1,000 members (MercyCare Plus, 3439.30, $z = -1.25$; 95% CI: 1756.82, 5121.78; $p < .05$) than the rate for all MO HealthNet Managed Care health plans.

In 2007 (see Figure 24), the EQRO found that the rate of Outpatient Hospital encounter claims per 1,000 members for all MO HealthNet Managed Care health plans was 5,547.72. The EQRO found that one MO HealthNet Managed Care health plan had a significantly higher rate of Outpatient Hospital encounter claims (Missouri Care, 8785.34, $z = 1.21$; 95% CI: 6530.31, 11040.37; $p < .01$). While one MO HealthNet Managed Care health plan had a significantly lower rate of Outpatient Hospital encounter claims per 1,000 members (Harmony Health Plan, 3.43, $z = -1.67$; 95% CI: -2251.60, 2258.46; $p < .01$) than the rate for all MO HealthNet Managed Care health plans.

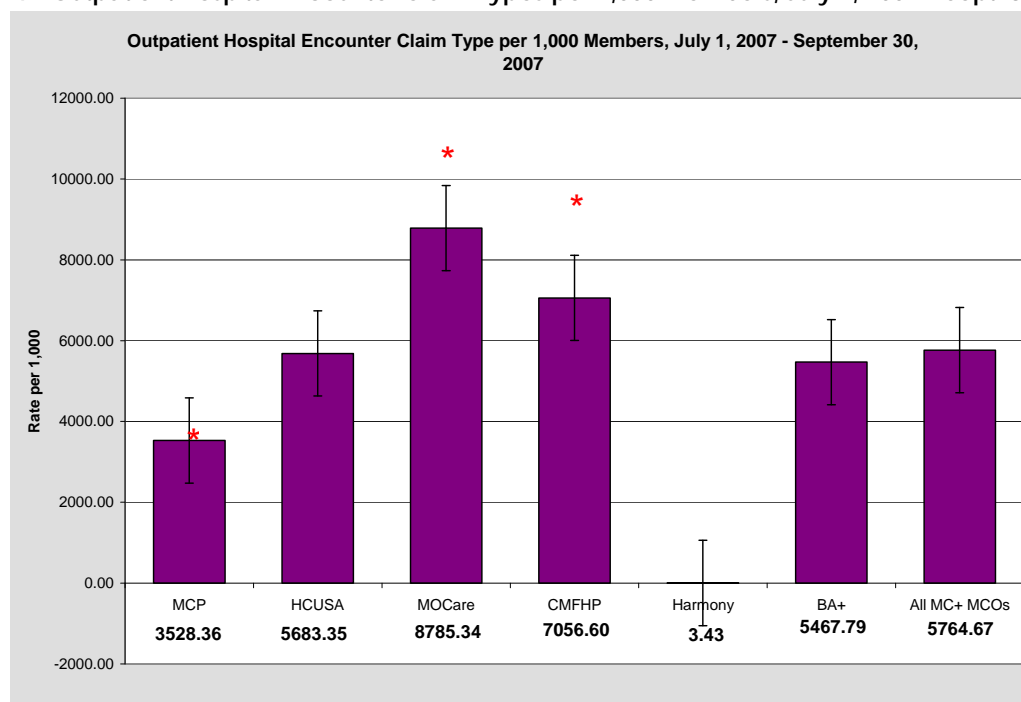
Figure 23 - Outpatient Hospital Encounter Claim Types per 1,000 Members, July 1, 2006 – Sept. 30, 2006



Note: Rate per 1,000 members is an estimated annual rate based on first quarter state encounter data; Rate per 1,000 members = Number Claims July 1, 2006 – September 30, 2006 / (Number members / 4) X 1,000. Enrollment as of the last week of September 2006 was used to calculate the rate per 1,000 members. Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.

Source: MO Dept of Social Services, Division of Medical Services, State Session MPRI screen, enrollment for all Waivers.

Figure 24 - Outpatient Hospital Encounter Claim Types per 1,000 Members, July 1, 2007 – Sept. 30, 2007



Note: Rate per 1,000 members is an estimated annual rate based on first quarter state encounter data; Rate per 1,000 members = Number Claims July 1, 2007 – September 30, 2007 / (Number members / 4) X

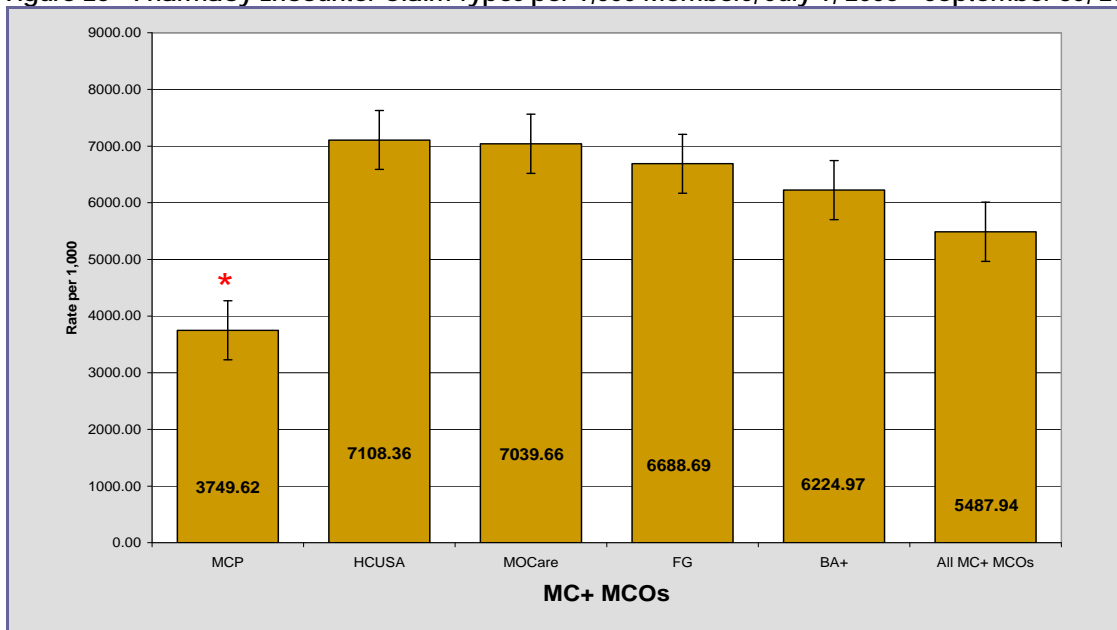
1,000. Enrollment as of the last week of September 2007 was used to calculate the rate per 1,000 members. Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.

Source: MO Dept of Social Services, MO HealthNet Division, State Session MPRI screen, enrollment for all Waivers.

Pharmacy encounter claim types consist of claims submitted by pharmacy providers and MO HealthNet Managed Care health plans. In 2006, as shown in Figure 25, there was little variability across MO HealthNet Managed Care health plans in the statewide rate per 1,000 members of Pharmacy encounter claims compared to the rate for all MO HealthNet Managed Care health plans (5487.94 Pharmacy encounter claims per 1,000 members). In this category, one MO HealthNet Managed Care health plan (MercyCare Plus, 3749.62; $z = -1.73$; 95% CI: 2717.34, 4781.90; $p < .05$) had a significantly lower rate of Pharmacy encounter claims. The other four MO HealthNet Managed Care health plans had a rate consistent with the rate for all MO HealthNet Managed Care health plans. This “all MO HealthNet Managed Care health plan” rate does not include pharmacy encounters for the MO HealthNet Managed Care health plan, Children’s Mercy Family Health Partners, this is due to the fact that CMFHP “carved – out” pharmacy encounters from their contract with the SMA beginning on July 1, 2006.

In 2007, as shown in Figure 26, there was wide variability across MO HealthNet Managed Care health plans in the rate per 1,000 members of Pharmacy encounter claims compared to the rate for all health plans. Missouri Care (7748.92, $z = 1.09$, 95% CI: 5267.69, 10230.15; $p < .01$) had a significantly higher rate of Pharmacy encounter claims, see Figure 31. While two MO HealthNet Managed Care health plans (Children’s Mercy Family Health Partners, 2.49, $z = -1.22$; 95% CI: -2478.74, 2481.23; $p < .01$; and Harmony Health Plan, 0.00, $z = -1.22$; 95% CI: -2481.23, 2481.23; $p < .01$) had a significantly lower rate of Pharmacy encounter claims per 1,000 members than the rate for all MO HealthNet Managed Care health plans.

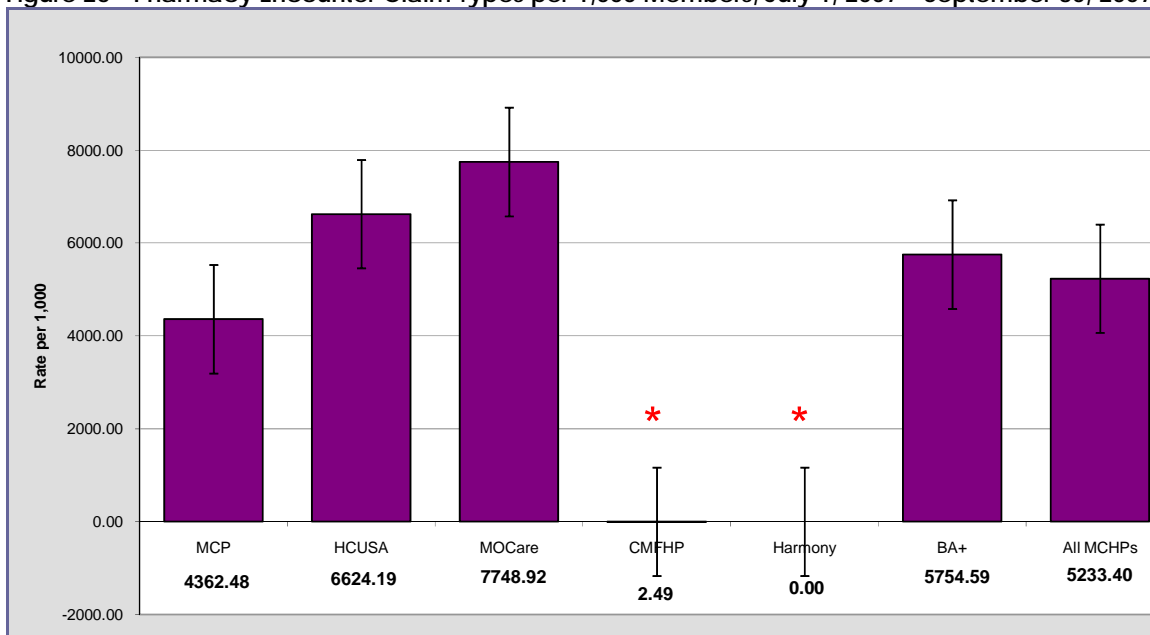
Figure 25 - Pharmacy Encounter Claim Types per 1,000 Members, July 1, 2006 – September 30, 2006



Note: Rate per 1,000 members is an estimated annual rate based on first quarter state encounter data; Rate per 1,000 members = Number Claims July 1, 2006 – September 30, 2006 / (Number members / 4) X 1,000. Enrollment as of the last week of September 2006 was used to calculate the rate per 1,000 members. Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.

Source: MO Dept of Social Services, Division of Medical Services, State Session MPRI screen, enrollment for all Waivers.

Figure 26 - Pharmacy Encounter Claim Types per 1,000 Members, July 1, 2007 – September 30, 2007



Note: Rate per 1,000 members is an estimated annual rate based on first quarter state encounter data; Rate per 1,000 members = Number Claims July 1, 2007 – September 30, 2007 / (Number members / 4) X 1,000. Enrollment as of the last week of September 2007 was used to calculate the rate per 1,000 members. Error bars on the y-axis represent 95% confidence intervals; * Indicates values are significant at the 95% level of significance, two-tailed z-test.

Source: MO Dept of Social Services, MO HealthNet Division, State Session MPRI screen, enrollment for all Waivers.

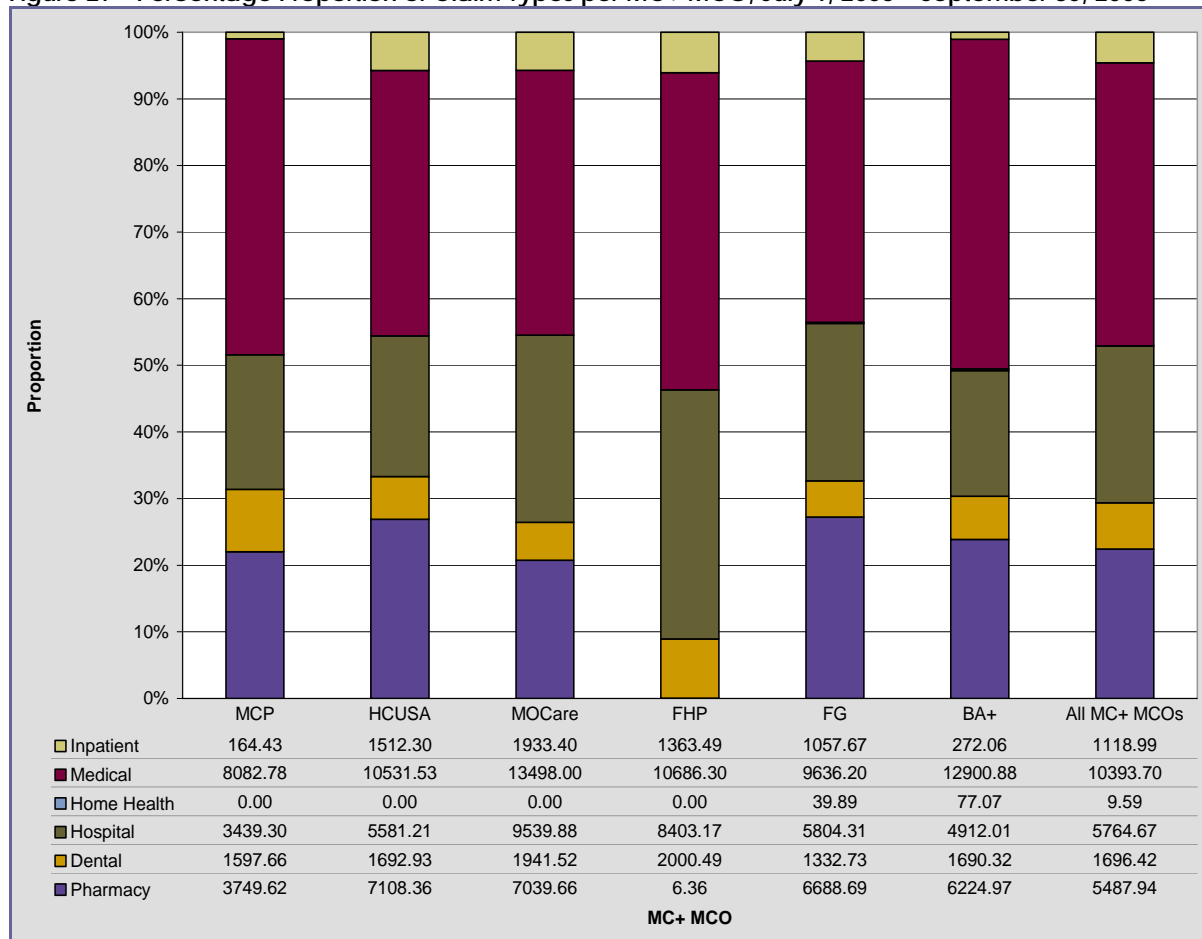
Table 36 and Figure 27 show the proportion of claim types for each MO HealthNet MCO based on the SMA encounter claims extract file. HealthCare USA had the highest proportion of Medical claims relative to all other MO HealthNet MCOs; Children’s Mercy Family Health Partners had the highest proportion of the Dental claim types; Blue-Advantage Plus of Kansas City had the highest proportion of Home Health and Inpatient claim types; and Missouri Care had the highest proportion of Hospital and Pharmacy claims. There were no patterns observed across MO HealthNet Plans, suggesting that the variations are not related to member or provider practice characteristics.

In 2006, Missouri Care had the highest proportion of Medical, Hospital and Inpatient claims; HealthCare USA had the highest proportion of Pharmacy claims; Blue-Advantage Plus of Kansas City again had the highest proportion of Home Health claims; and Children’s Mercy Family Health Partners again had the highest proportion of Dental claims relative to all other MO HealthNet Managed Care health plans (see Table 37 and Figure 28).

Table 36 - Numerical Proportion of Claim Types per MC+ MCO, July 1, 2006 –September 30, 2006

MCHP	Medical	Dental	Inpatient	Home Health	Hospital	Pharmacy
MCP	8082.78	1597.66	164.43	0.00	3439.30	3749.62
HCUSA	10531.53	1692.93	1512.30	0.00	5581.21	7108.36
MOCare	13498.00	1941.52	1933.40	0.00	9539.88	7039.66
FHP	10686.30	2000.49	1363.49	0.00	8403.17	0.00
FG	9636.20	1332.73	1057.67	39.89	5804.31	6688.69
BA+	12900.88	1690.32	272.06	77.07	4912.01	6224.97
All MC+ MCOs	10393.70	1696.42	1118.99	9.59	5764.67	5487.94

Figure 27 - Percentage Proportion of Claim Types per MC+ MCO, July 1, 2006 – September 30, 2006

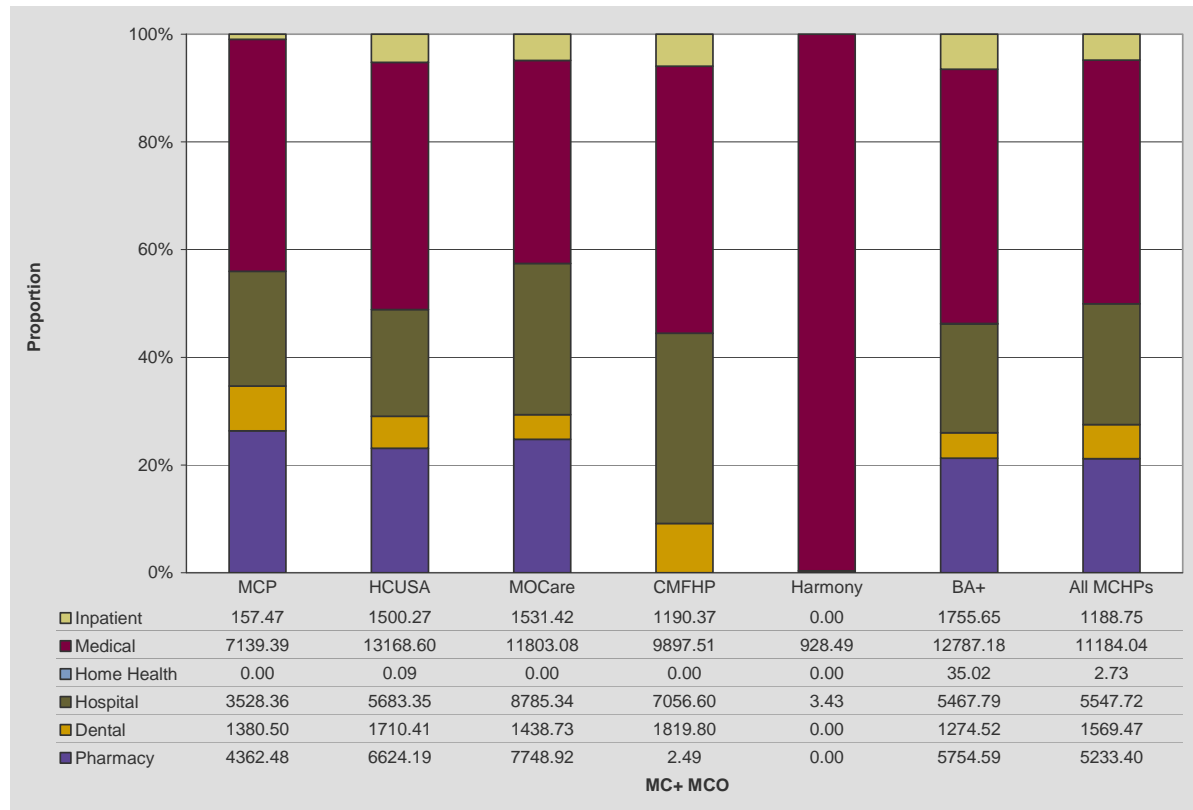


Source: Missouri Department of Social Services, Division of Medical Services encounter claims extract file, February 15, 2007.

Table 37 - Numerical Proportion of Claim Types per MO HealthNet Managed Care health plan, July 1, 2007 – September 30, 2007

MCHP	Medical	Dental	Inpatient	Home Health	Hospital	Pharmacy
MCP	7139.39	1380.50	157.47	0.00	3528.36	4362.48
HCUSA	13168.60	1710.41	1500.27	0.09	5683.35	6624.19
MOCare	11803.08	1438.73	1531.42	0.00	8785.34	7748.92
CMFHP	9897.51	1819.80	1190.37	0.00	7056.60	2.49
Harmony	928.49	0.00	0.00	0.00	3.43	0.00
BA+	12787.18	1274.52	1755.65	35.02	5467.79	5754.59
All MCHPs	11184.04	1569.47	1188.75	2.73	5547.72	5233.40

Figure 28 - Percentage Proportion of Claim Types per MO HealthNet Managed Care health plan, July 1, 2007 – September 30, 2007



Source: Missouri Department of Social Services, MO HealthNet Division encounter claims extract file, February 15, 2008.

Table 38 - MO HealthNet MCOs, Rate per 1,000 Members all Encounter Claims

Claim Type	Number of Claims	Total Members	Claims Per 1000 Members
Home Health	235	343,998	0.68
Dental	134,974	343,998	392.37
Medical	961,822	343,998	2,796.01
Outpatient	477,101	343,998	1,386.93
Drug	450,070	343,998	1,308.35
Inpatient	102,232	343,998	297.19

Note: Rate per 1,000 members is an estimated annual rate based on third quarter state encounter data; Rate per 1,000 members = Number Claims July 1, 2007 – September 30, 2007 / (Number members) X 1,000. Enrollment as of the last week of September 2007 was used to calculate the rate per 1,000 members. Source: Missouri Department of Social Services, MO HealthNet Division encounter claims extract file.

To What Extent do the MO HealthNet MCHP claims (paid and unpaid) match the State Encounter Claims Paid Claims Data Base?

All six MO HealthNet Managed Care health plans submitted the requested internal control numbers (ICNs) generated by the SMA data system for the “paid” vs. “unpaid” analysis. Health Care USA, Missouri Care, Children’s Mercy Family Health Partners, Blue-Advantage Plus of Kansas City, and Harmony Health Plan of Missouri submitted encounter claims that were “paid” or “denied” status. Harmony Health Plan, Missouri Care and Blue-Advantage Plus of Kansas City also submitted claims with a status of “unpaid”.

The ICNs were used to match the encounters of each claim type (Inpatient, Outpatient, and Pharmacy) between the MO HealthNet Managed Care health plan and the SMA extract files. A “match” was considered if the MO HealthNet Managed Care health plan sample encounter was identified in the SMA database.

What types of paid encounter data are missing and why?

There were no unmatched “paid” encounters within all claim types (Inpatient, Outpatient, and Pharmacy) for all MO HealthNet Managed Care health plans.

For all MO HealthNet Managed Care health plans, all unmatched encounters were due to missing ICN numbers, which are required to match the encounter to that of the SMA. There were no unmatched encounters within the Pharmacy Claim type. For the Outpatient data, 100.00% of the 535 unmatched claims were missing ICN numbers. Of the 535 unmatched claims, 424 of those were of “denied” status and would not be expected to be present in the SMA file. For Inpatient Claims, all 299 unmatched claims were missing ICNs. Therefore, all were legitimately missing from the SMA file.

What is the fault/match rate of paid and unpaid encounter claims in the SMA encounter claim database and the MO HealthNet MCHP claims database?

For all Outpatient Claim Types (Medical, Dental, Home Health, & Hospital; n = 1,574,132), 481 "denied" claims were submitted by all MO HealthNet Managed Care health plans. All of these claims were unmatched with the SMA encounter data. There was a "hit" rate of 99.96% between Outpatient encounter claims and the SMA encounter data. For the Inpatient Claim Type, data submitted to the EQRO (n = 102,232), 332 "denied" claims were submitted. These claims were not found in the SMA encounter data. There were a total of 223 unmatched records (6 "unpaid" claims were submitted) between all MO HealthNet MCOs and the SMA, yielding a 99.94% "hit" rate.

What services are being provided that are not being paid and how many services are being provided that are not being paid?

Unpaid encounter claims were submitted for only Outpatient and Inpatient categories. 6 unpaid claims were submitted for all MO HealthNet MCOs for all Outpatient claims and Inpatient services. These unpaid claims represent less than .01% of all claims submitted to the SMA.

To What Extent Do the Claims in the State Encounter Claims Database Reflect the Information Documented in the Medical Record? What is the Fault/Match Rate between State Encounter Claims and Medical Records?

Table 39 shows the population (number of encounters), minimum required sample size, the number of encounters sampled, and the number and rate of records submitted for review. Of the 2,126,434 encounter claim types in the SMA encounter claims extract file for July 1, 2007 through September 30, 2007, 600 encounters (100 per MO HealthNet Managed Care health plan) were randomly selected. This was an oversample, as the minimum required sample size was 88 per MO HealthNet Managed Care health plan. Providers were requested to submit medical records for review. For the 600 selected encounters, there were 561 medical records (93.50%) submitted for review. Although this is a substantial increase over the 86.71% submitted for review during the 2005 audit, it was a decrease from the 97.40% submitted for the 2006 audit. For 2007, MO HealthNet Managed Care health plan submission rates ranged from 88.0% (Children's Mercy Family Health Partners) to 98.0% (Missouri Care). Encounters for which no documentation was submitted were unable to be validated. Table 40 and Figure 29 show the results of the match for procedures. Across all MO HealthNet MCOs, 52.00% of the medical records contained matching procedure codes or descriptors; this is a decrease of 21.24% from the 2006 audit which found 73.24% of the medical records contained matching procedure codes or descriptors. MO HealthNet Managed Care health plan match rates ranged from 45.0% (Harmony Health Plan) to 58.0% (Missouri Care). One MO HealthNet Managed Care health plan (Missouri Care, 58.0%; $z = 1.69$, 95% CI: 54.86, 61.14; $p < .05$) had match rates significantly higher than the rate for all MO HealthNet Managed Care health plans. The remaining five MO HealthNet Managed Care health plans had match rates consistent with the rate for all MO HealthNet MCOs. The CMS Protocols suggest a 99% match rate as a validity criterion. When considering only the documentation submitted for review, the match rate for all MO HealthNet Managed Care health plans for procedures was 55.61%

Table 39 - Encounter Data Validation Samples and Medical Record Submission Rate

MO HealthNet MCHP	Number Encounters	Minimum Sample Size	Number Encounters Sampled	Number Medical Records Received	Submission Rate
MercyCare Plus	280,189	88	100	94	94.00%
Health Care USA	1,235,187	88	100	93	93.00%
Missouri Care	214,472	88	100	98	98.00%
Family Health Partners	216,345	88	100	88	88.00%
Blue-Advantage Plus	178,612	88	100	97	97.00%
Harmony Health Plan	1,629	88	100	91	91.00%
All Health Plans	2,126,434	528	600	561	93.50%

Note: The number of encounters represents the number of unique Medical claim types found in the SMA encounter claims extract file for the period July 1, 2007 through September 30, 2007. The minimum sample size is based on the validation of medical records for two dependent variables, the procedure code and the diagnosis code. Number Encounters Sampled = Number of unique encounters randomly sampled by the EQRO for medical record review validation. Number Medical Records Received = Number medical records submitted by MO HealthNet Managed Care health plan providers; Number Claim Forms Received = Number claim forms submitted by MO HealthNet MCHP providers; Submission Rate = Proportion of medical records submitted of the number of encounters sampled.

Source: Missouri Department of Social Services, Division of Medical Services encounter claims extract file, January 2008.

BHC, Inc. 2007 External Quality Review Validation of Encounter Data.

Table 40 - Procedure Validation Rate

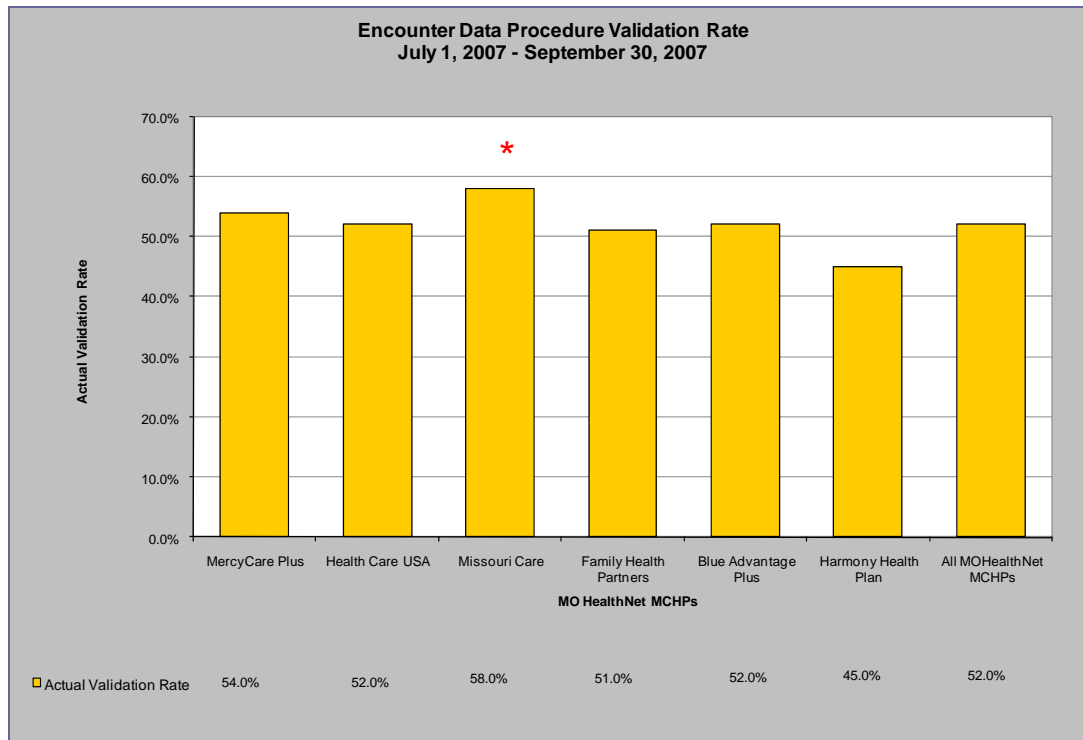
MO HealthNet MCHPs	Number Encounters Sampled	Number Medical Records Received	Number Validated	Rate Validated of Medical Records Received	Actual Validation Rate	Error (Fault) Rate	z	p	LCL	UCL
MercyCare Plus	100	94	54	57.45%	54.00%	46.00%	1.2838251	0.284	50.86%	57.14%
Health Care USA	100	93	52	55.91%	52.00%	48.00%	0.9225336	0.853	48.86%	55.14%
Missouri Care	100	98	58	59.18%	58.00%	42.00%	1.6932081	0.038	54.86%	61.14%
Family Health Partners	100	88	51	57.95%	51.00%	49.00%	1.4034998	0.173	47.86%	54.14%
Blue Advantage Plus	100	97	52	53.61%	52.00%	48.00%	0.3790676	0.252	48.86%	55.14%
Harmony Health Plan	100	91	45	49.45%	45.00%	55.00%	-0.6009113	0.763	41.86%	48.14%
All MCHPs	600	561	312	55.61%	52.00%	48.00%	0.8520574	0.000	48.86%	55.14%

Note: Number Encounters Sampled = Number of unique encounters randomly sampled by the EQRO for medical record review validation; Number Medical Records Received = Number medical records submitted by MO HealthNet Managed Care health plan providers for validation; Number Validated = Number of encounters for which there was a similar or matching procedure code or description on the claim form, or adequate documentation in the medical record to support the procedure code as judged by a professional medical coder. Rate Validated of Medical Records Received = Number Validated/Number Medical Records Received; Actual Rate Validated = Number Validated/Number Encounters Sampled; LCL = Lower Confidence Limit at the 95% confidence level; UCL = Upper Confidence Limit at the 95% confidence level.

Source: Missouri Department of Social Services, Division of MO HealthNet encounter claims extract file, January 2008.

BHC, Inc. 2007 External Quality Review Validation of Encounter Data.

Figure 29 - Encounter Data Procedure Validation Rate, July 1, 2007 – September 30, 2007



Note: * Indicates values are significant at the 95% level of significance, two-tailed z-test. See corresponding tables for 95% confidence intervals.

Source: Missouri Department of Social Services, Division of Medical Services encounter claims extract file, January 15, 2008. BHC, Inc. 2007 External Quality Review Validation of Encounter Data.

For the validation of the diagnosis, 47.0% matched the diagnosis found in the SMA encounter claims extract file across all MO HealthNet Managed Care health plans (see Table 41 and Figure). This was a significant decrease from the 2006 audit when the EQRO found that 70.56% matched the diagnosis found in the SMA encounter claims extract file. For the 2007 audit, MO HealthNet Managed Care health plan match rates ranged from 36.0% (Harmony Health Plan) to 60.0% (Missouri Care) of the medical records or claim forms for diagnosis codes. Two MO HealthNet Managed Care health plans (Missouri Care, 60.0%, $z = 1.38$, 95% CI: 51.73, 68.27; $p < .01$ and Blue-Advantage Plus of Kansas City, 59.0%, $z = 1.34$, 95% CI: 50.73, 67.27; $p < .01$) had match rates significantly higher than the rate for all MO HealthNet Managed Care health plans; while two MO HealthNet Managed Care health plans (Harmony Health Plan, 36.0%, $z = -.72$, 95% CI: 27.73, 44.27; $p < .01$ and HealthCare USA, 39.0%, $z = -.49$, 95% CI: 30.73, 47.27; $p < .01$) had a significantly lower rate. The CMS Protocol suggests a greater than 90%

validity criterion.¹⁷ No MO HealthNet Managed Care health plan met that validity criterion.

¹⁷ Validating Encounter Data, A protocol for use in Conducting Medicaid External Quality Review Activities, Department of Health and Human Services, Centers for Medicare and Medicaid Services, Final Protocol, Version 1.0, May 1, 2002.

Table 41 – Encounter Data Diagnosis Validation Rate- July 1, 2007 – September 30, 2007

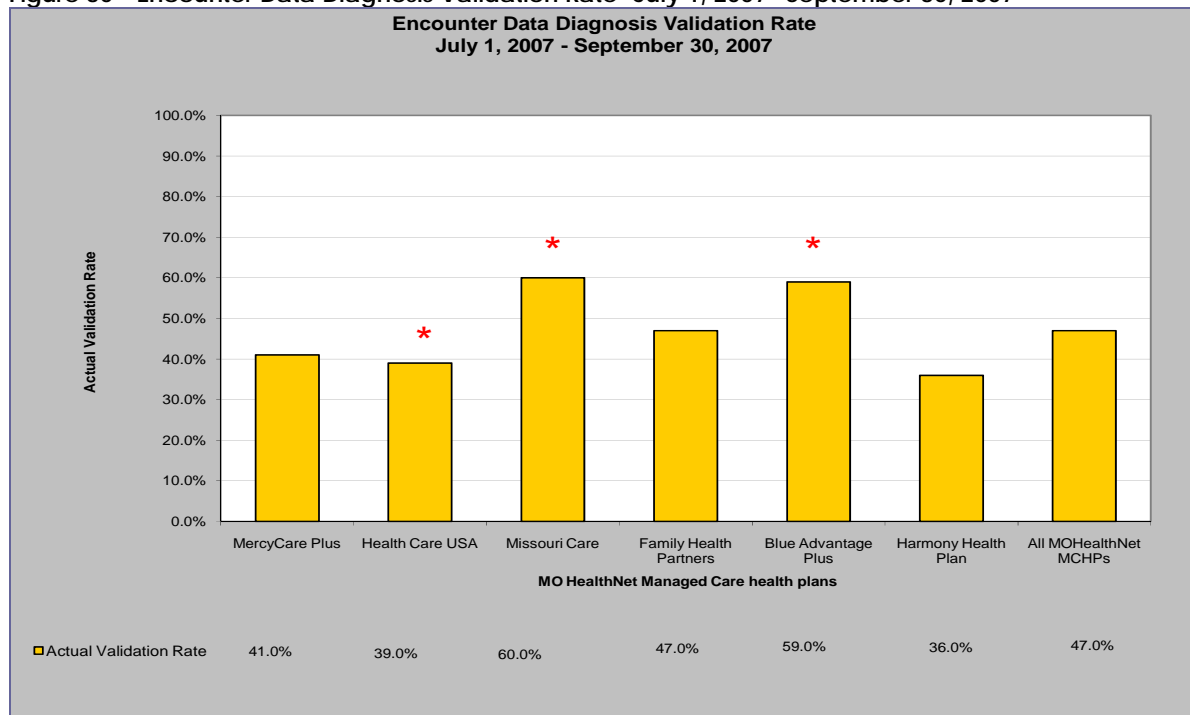
MCHP	Number Encounters Requested	Number Medical Records Received	Number Validated	Rate Validated of Medical Records Received	Actual Validation Rate	Error (Fault) Rate	z	p	LCL	UCL
MercyCare Plus	100	94	41	43.62%	41.00%	59.00%	0.3273510	0.125	32.73%	49.27%
Health Care USA	100	93	39	41.94%	39.00%	61.00%	0.4900635	0.000	30.73%	47.27%
Missouri Care	100	98	60	61.22%	60.00%	40.00%	1.3764203	0.008	51.73%	68.27%
Family Health Partners	100	88	47	53.41%	47.00%	53.00%	0.6201701	0.432	38.73%	55.27%
Blue Advantage Plus	100	97	59	60.82%	59.00%	41.00%	1.3377391	0.011	50.73%	67.27%
Harmony Health Plan	100	91	36	39.56%	36.00%	64.00%	0.7198826	0.000	27.73%	44.27%
All MCHPs	600	561	282	50.27%	47.00%	53.00%	0.3161651	0.967	38.73%	55.27%

Note: Number Encounters Sampled = Number of unique encounters randomly sampled by the EQRO for medical record review validation; Number Medical Records Received = Number medical records submitted by Health Plan providers for validation; Number Validated = Number of encounters for which there was a matching diagnosis code, documentation or description in the medical record or on the claim form. Rate Validated of Medical Records Received = Number Validated/Number Medical Records Received; Actual Rate Validated = Number Validated/Number Encounters Sampled; LCL = Lower Confidence Limit at the 95% confidence level; UCL = Upper Confidence Limit at the 95% confidence level.

Source: Missouri Department of Social Services, Division of Medical Services encounter claims extract file, December 15, 2007.

BHC, Inc. 2007 External Quality Review Validation of Encounter Data.

Figure 30 - Encounter Data Diagnosis Validation Rate- July 1, 2007– September 30, 2007



Note: Encounters Sampled = Number of unique encounters randomly sampled by the EQRO for medical record review validation; Number Medical Records Received = Number medical records submitted by Health Plan providers for validation; Number Validated = Number of encounters for which there was a matching diagnosis code, documentation or description in the medical record or on the claim form. Rate Validated of Medical Records Received = Number Validated/Number Medical Records Received; Actual Rate Validated = Number Validated/Number Encounters Sampled; LCL = Lower Confidence Limit at the 95% confidence level; UCL = Upper Confidence Limit at the 95% confidence level.

Source: Missouri Department of Social Services, MO HealthNet Division encounter claims extract file, January 15, 2008. BHC, Inc. 2007 External Quality Review Validation of Encounter Data.

What Types of Errors Were Noted?

An error analysis for procedure and diagnosis codes was conducted. For the diagnosis code in the medical record, the reasons for diagnosis codes not matching the SMA encounter claims extract file were incorrect information (n = 28) and missing information (n = 251). Incorrect information included that the diagnosis code listed did not match the descriptive information in the record. Missing information included the coders being unable to find a diagnosis code or diagnosis description in the medical records received for review.

For the procedure code in the medical record, the reasons for procedure codes in the SMA encounter claims extract file not being supported by documentation in the medical record were missing information (n = 198), upcoding (n=18), downcoding (n=7) and incorrect codes (n = 26). Examples of incorrect information included: incorrect codes (n = 20) and codes that did not match the procedure description (n = 6).

What Problems Are There With How Files Are Compiled and Submitted by the MCHP?

The EQRO had no problems with how files are compiled and submitted by each MO HealthNet Managed Care health plan.

What Are the Data Quality Issues Associated With the Processing of Encounter Data?

The EQRO had no data quality issues with SMA and MO HealthNet Managed Care health plan encounter data during the course of conducting the EQRO. This was only the second year of the EQR that the EQRO has received all encounter data in the format requested.

4.5 Conclusions

STRENGTHS

1. All Dental and Pharmacy claim type fields examined were 100.00% complete, accurate and valid for all MO HealthNet Managed Care health plans. The SMA encounter claims data critical fields examined for accepted and paid claims of this type are valid for analysis.
2. For all MO HealthNet Managed Care health plans, the first Outpatient

Diagnosis Code field was 100.0% complete, accurate and valid.

3. All MO HealthNet Managed Care health plans submitted data in the format requested, and the EQRO was able to perform the analysis of paid and unpaid claims contained in the SMA database.
4. The examination of the level, volume, and consistency of services found significant variability between MO HealthNet Managed Care health plans in the rate of each type of claim (Medical, Dental, Inpatient, Outpatient Hospital, Home Health, and Pharmacy), with no patterns of variation noted by Region or type of MO HealthNet Managed Care health plan.
5. MO HealthNet Managed Care health plan members are receiving more services than their fee-for-services counterparts. The claims data presented details a much higher rate of claims per 1,000 members for MO HealthNet Managed Care members. This is likely due to a greater availability of needed services, more access points to care, and the timeliness in which those services are delivered.
6. MO HealthNet Managed Care health plan members received a substantially larger portion of all Outpatient services delivered in Missouri during the 2007 measurement period versus the 2006 measurement period.
7. There were no unmatched “paid” encounters within all claim types (Inpatient, Outpatient, and Pharmacy) for all Managed Care health plans.
8. Unpaid claims represent less than .01% of all claims submitted to the SMA.

AREAS FOR IMPROVEMENT

1. For all MO HealthNet Managed Care health plans, all unmatched encounters were due to missing ICN numbers, which are required to match the encounter to that of the SMA.
2. The Procedure Code field in the Outpatient Home Health and Outpatient

Hospital claim types included some invalid information. Most of this was due to blank fields or fields containing "00000".

3. The Inpatient first diagnosis claim field contained incomplete, invalid, and inaccurate fields.
4. The match rates between the SMA database and MO HealthNet Managed Care health plan medical records for claim type procedures were 52.0%, a significant decrease from last year's match rate of 73.24%. Medical records that did not have procedure codes that matched the SMA encounter claims extract file were in error primarily due to missing or incorrect information.
5. The match rates between the SMA database and MO HealthNet Managed Care health plan medical records for claim type diagnoses were 47.0%, this is significantly lower than last year's match rate of 70.56%. Medical records that did not have procedure codes that matched the SMA encounter claims extract file were in error primarily due to missing or incorrect information.

RECOMMENDATIONS

1. It is recommended that the SMA institute additional edits for the Medical, Inpatient and Outpatient Hospital claim types to edit claims with blank fields or dummy values (e.g., "000" and "99999999").
2. The SMA should continue to provide timely feedback to MO HealthNet Managed Care health plans regarding the rate of acceptance of each claim type and the types of errors associated with rejected claims.
3. Additional analysis on the rate of consistency of services should examine demographic (e.g., age and gender distribution), epidemiological (diagnostic variables), and service delivery (e.g., number of users per month, rate of procedures or claim types, units of service rates) characteristics to explain variation across MO HealthNet Managed Care

- health plans or Regions.
4. MO HealthNet Managed Care health plans' medical record reviews should be targeted toward validation of diagnosis and procedure codes and/or descriptors.
 5. The SMA should clarify the expectations for MO HealthNet Managed Care health plans in the level of completeness, accuracy, and validity and which data fields are required (e.g., Diagnosis Code fields 2 through 5); provide timely feedback to MO HealthNet Managed Care health plans when standards are not met; and develop corrective action plans when standards are not met within a reasonable amount of time established by the SMA.
 6. The MCHP should investigate and report to the SMA the reasons for and corrective action to prevent the substantial decline in medical records matches for both diagnoses and procedures between the 2006 and 2007 EQR reports.

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5.0 MO HealthNet MCHP COMPLIANCE WITH MANAGED CARE REGULATIONS

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5.1 Purpose and Objectives

The External Quality Review (EQR) is conducted annually in accordance with the Medicaid Program: External Quality Review of the Medicaid Managed Care Organizations Final Rule, 42 CFR 438, Subpart E.” The original objective of this portion of the 2004 review was to analyze and evaluate the MO HealthNet Managed Care health plans to assess their level of compliance with federal regulations regarding quality, timeliness and access to health care services. In the two subsequent years, beginning in 2005 and culminating in 2006, the objective is to complete follow-up reviews to ensure improved and continued compliance with these regulations on the part of the MO HealthNet MCHPs. To complete this process, the Monitoring Medicaid Managed Care Organizations (MCHPs) and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance with Medicaid Managed Care Regulations (Compliance Protocol) requirements was applied to the review process, with an emphasis on areas where individual MCHPs failed to comply or were in only partial compliance at the time of the prior reviews. Specifically, the MCHPs were reviewed to assess MO HealthNet MCHP compliance with the federal Medicaid managed care regulations; with the State Quality Strategy; with the MO HealthNet contract requirements; and the progress made in achieving quality, access, and timeliness to services from the previous review year. To enhance this process in 2006 two additional activities occurred. A case review of Grievance and Appeal files, following up on findings from 2004 and 2005, was completed. A second case review focusing on Behavioral Health Case Management files, a follow-up from the 2003 External Quality Review occurred.

The current 2007 report on compliance with federal regulations is again a full compliance review. However, as previous reviews revealed the MO HealthNet Managed Care health plans have nearly reached full compliance with completing written policy and procedures that meet both the requirements of

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the federal regulations and the MO HealthNet Division (MHD), which is the State agency administering the federal Medicaid program (SMA). To enhance the review it was decided to complete in-depth interviews with Member Services Staff, Case Management Staff, and health plan administrators. The Member Services Staff and Case Managers have direct contact with members and are responsible for communicating the services available to members, members' rights and responsibilities, and ensuring that members have appropriate access to quality and timely health care. These interviews were designed to validate that the actual practices occurring at the MO HealthNet Managed Care health plans were compliant with the written policy and procedures developed by the health plans and approved by the SMA.

5.2 Technical Methods

PLANNING COMPLIANCE MONITORING ACTIVITIES

Establishing Contact with the MO HealthNet MCOs

All MO HealthNet Managed Care health plans were contacted during November 2007 to prepare them for the 2007 External Quality Review. All MO HealthNet Managed Care health plan quality management staff and/or plan administrators were contacted to discuss the onset of External Quality Review Organization (EQRO) activities and to schedule training teleconferences for early December. The MCHPs were explicitly requested to have those staff or subcontractors available who were responsible for obtaining and submitting the data required to complete all validation processes. During the teleconferences, all aspects of the EQR were discussed and details provided regarding all data submissions that would be required.

The training teleconference agenda, methods and objectives, and schedule were sent to all MO HealthNet Managed Care health plans, with approval from

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the State Medicaid Agency (SMA), prior to their scheduled conference. SMA staff arranged to participate in these conference calls allowing time for presentation of information, clarification, and questions.

Gathering Information on the MO HealthNet MCHP Characteristics

During the 2007 review year there were six MO HealthNet Managed Care health plans contracted with the State Medicaid Agency (SMA) to provide MO HealthNet Managed Care in three Regions of Missouri. The Eastern Region includes St. Louis City, St. Louis County, and eight surrounding counties. These MO HealthNet Members are served by three MO HealthNet Managed Care health plans: Mercy CarePlus (MCP), HealthCare USA (HCUSA), and Harmony Health Plan of Missouri (HHP). The Western includes Kansas City/Jackson County and eight surrounding counties. These MO HealthNet members are served by four MO HealthNet Managed Care health plans: Children's Mercy Family Health Partners (CMFHP), Blue-Advantage Plus (BA+), Mercy CarePlus (MCP), and HealthCare USA (HCUSA). The Central Region includes eighteen counties in the center of the state. These MO HealthNet members are served by three MO HealthNet Managed Care health plans: Missouri Care (MOCare), Mercy CarePlus (MCP), and HealthCare USA (HCUSA). Mercy CarePlus and HealthCare USA operated in all three Regions.

Determining the Length of Visit and Dates

On-site compliance reviews were conducted in two days at each MO HealthNet Managed Care health plan, with several reviewers conducting interviews and activities concurrently. Document reviews occurred prior to the complete on-site review at all MO HealthNet Managed Care health plans, with the exception of Harmony Health Plan of Missouri. All review activities were completed in a one day visit at Harmony Health Plan who accommodated the document review activities by preparing information for reviewers to take with them for completion after the date of the actual on-site visit. Interviews, presentations, and additional

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document reviews were scheduled throughout the day, utilizing different team members for Validating Performance Measures, Validating Performance Improvement Projects, Monitoring Medicaid Managed Care Organizations (MCHPs) and Prepaid Inpatient Health Plans (PIHPs). The time frames for on-site reviews were determined by the EQRO and approved by the SMA before scheduling each MO HealthNet Managed Care health plan. The first week was spent reviewing the MO HealthNet Managed Care health plans in the Eastern Region. The second review week was spent in the Central Region. The final visits occurred with the health plans in the Western Region. The following schedule lists the dates of the on-site reviews:

- July 7 & 8, 2008 – Mercy CarePlus
- July 7 & 9, 2008 – HealthCare USA
- July 10, 2008 – Harmony Health Plan
- July 15 & 16, 2008– Missouri Care
- July 21 & 22, 2008 – Children’s Mercy Family Health Partners
- July 21 & 23, 2008 – Blue-Advantage Plus

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Reviewers

Two reviewers conducted the Compliance Protocol activities, including interviews and document review. The External Quality Review Organization (EQRO) Project Director conducted backup activities and oversight of the Compliance Protocol team. The Assistant Project Director was conducting her fourth review. She has experience with the MO HealthNet Managed Care Program implementation and operations, interviewing, program analysis, and Medicaid managed care programs in other states. The second reviewer participated in six previous MO HealthNet Managed Care Program EQRs and on-site visits. This reviewer was knowledgeable about the MO HealthNet Managed Care Program through her experience as a former SMA employee responsible for quality assessment and improvements, as an RN, and a consultant. All reviewers were familiar with the federal regulations and the manner in which these were operationalized by the MO HealthNet Managed Care Program prior to the implementation of the protocols.

Establishing an Agenda for the Visit

An agenda was developed to maximize the use of available time, while ensuring that all relevant follow-up issues were addressed. A sample schedule was developed that specified times for all review activities including the entrance conference, document review, Validating Performance Improvement Project evaluation, Validating Performance Measures review, conducting the interview for the Compliance Protocol, and the exit conference. A coordinated effort with each MO HealthNet Managed Care health plan occurred to allow for the most effective use of time for the EQRO team and health plan staff. The schedule for the on-site reviews was approved by the SMA in advance and forwarded to each health plan to allow them the opportunity to prepare for the review. Appendix 11 provides a sample agenda for the on-site reviews.

Providing Preparation Instructions and Guidance to the MO HealthNet MCOs



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A letter (see Appendix 14) was sent to each MO HealthNet Managed Care health plan indicating the specific information and documents required on-site, and the individuals requested to attend the interview sessions. The health plans scheduled their own staff to ensure that appropriate individuals were available and that all requested documentation was present during the on-site review day.

OBTAINING BACKGROUND INFORMATION FROM THE STATE MEDICAID AGENCY

Interviews and meetings occurred with individuals from the SMA from September 2007 through June 2008 to prepare for the on-site review, and obtain information relevant to the review prior to the on-site visits. Individuals from the SMA included in these meetings were:

- Sandra Levels, Director of Program Management
- Susan Eggen – Assistant Deputy Director, MO HealthNet Managed Care
- Andrea Smith – Quality Nurse Reviewer

In February 2008, Compliance Review team members requested the contract compliance documents prepared annually by the SMA. The latest information on health plan compliance with the July 1, 2006 MO HealthNet Managed Care contract was reviewed, along with required annual submission and approval information. All documentation gathered by the SMA was clarified and discussed to ensure that accurate interpretation of the SMA findings was reflected in the review comments and findings. The SMA staff continued to complete their review of health plan policy submissions. They provided periodic updates on approvals throughout the EQR preparation up to the beginning of the on-site review process. SMA expectations, requirements, and decisions specific to the MO HealthNet Managed Care Program were identified during these discussions.

DOCUMENT REVIEW

Documents chosen for review were those that best demonstrated each MO HealthNet Managed Care health plan's ability to meet federal regulations. Certain documents, such as the Member Handbook, provided evidence of communication to members about a broad spectrum of information including enrollee rights and the grievance and appeal process. Provider handbooks were reviewed to ensure that consistent information was shared regarding

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enrollee rights and responsibilities. SMA MO HealthNet Managed Care contract compliance worksheets, and specific policies that are reviewed annually or that are yet to be approved by the SMA, were reviewed to verify the presence or absence of evidence that required written policies and procedures existed meeting federal regulations. Other information, such as the Annual Quality Improvement Program Evaluation, was requested and reviewed to provide insight into the health plan's report of their compliance with the requirements of the MO HealthNet Managed Care contract and the federal regulations. Tracking logs relating to a number of issues were reviewed and discussed at the request of the SMA, to ensure that local procedures and practices corresponded to the written policies submitted for approval. When it was found that specific regulations were "Partially Met," additional documents were requested of each health plan. In addition, in-depth interview questions were developed for Member Services and Case Management staff to establish that practice directly with members reflected the health plans' written policies and procedures. Interviews with administrative staff also occurred to address the areas for which compliance was not fully established through the pre-site document review process, and to clarify responses received from the staff interviews.

The following documents were reviewed for all MO HealthNet MCHPs:

- State contract compliance ratings from 2007 and updated policies accepted through June 2008
- Results, findings, and follow-up information from the 2006 External Quality Review
- 2007 Annual MO HealthNet MCHP Evaluation, submitted April 2008

CONDUCTING INTERVIEWS

After discussions with the SMA, it was decided that the 2007 Compliance Review would include in-depth interviews with Member Services and Case Management

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Staff. The goal of these interviews was to validate that practices at the health plans, particularly those directly affecting members' access to quality and timely health care, were in compliance with the approved policies and procedures. After completing the initial document review, it was clear that the MO HealthNet Managed Care health plans had made significant progress in developing and obtaining approval of written policies and procedures. The interview questions were developed using the guidelines available in the Compliance Protocol. Previous interviews, generally conducted with administrative and management level health plan staff, did enable reviewers to obtain a clearer picture of the degree of compliance achieved through policy implementation. Corrective action taken by each health plan was determined from previous years' reviews. This process revealed a wealth of information about the approach each health plan took to become compliant with federal regulations. The current process of a document review, supported by interviews with front line staff, was developed to provide evidence of systems that delivered quality and timely services to members, and the degree to which appropriate access was available. The interviews provided reviewers with the opportunity to explore issues not addressed in the documentation. Additionally, this approach would continue to provide follow-up from previous EQRO evaluations. A site visit questionnaire for Member Services staff, case managers, and administrators was developed for the health plans. The questions were developed to seek concrete examples of activities and responses that would validate that these activities are compliant with contractual requirements and federal regulations.

COLLECTING ACCESSORY INFORMATION

Additional information used in completing the compliance determination included: discussions with the EQR reviewers and MO HealthNet health plan QI/UM staff regarding management information systems; Validating Encounter Data; Validating Performance Measures; and Validating Performance

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Improvement Projects. The review evaluated information from these sources to validate health plan compliance with the pertinent regulatory provisions within the Compliance Protocol. These findings were documented on the BHC MO HealthNet Managed Care Compliance Review Scoring Form (Appendix 12), and were used to make final rating recommendations.

ANALYZING AND COMPILING FINDINGS

The review process included gathering information and documentation from the SMA about policy submission and approval, which directly affects each MO HealthNet Managed Care health Plan's contract compliance. This information was analyzed to determine how it related to compliance with the federal regulations. Next, interview questions were prepared, based on the need to investigate if practice existed in areas where approved policy was or was not available, and if local policy and procedures were in use when approved policy was not complete. The interview responses and additional documentation obtained on-site were then analyzed to evaluate how they contributed to each health plan's compliance. All information gathered was assessed, re-reviewed and translated into recommended compliance ratings for each regulatory provision. This information was recorded on the MO HealthNet Managed Care scoring form and can be found in the protocol specific sections of this section of the report.

REPORTING TO THE STATE MEDICAID AGENCY

During the August 2008 meeting with the SMA, preliminary findings and comparisons to the ratings from the 2006 review were presented. Discussion occurred with the SMA staff to ensure that the most accurate information was recorded and to confirm that a sound rationale was used in rating determinations. The SMA approved the process and allowed the EQRO to finalize the ratings for each regulation. Sufficient detail is included in all worksheets to substantiate any rating lower than “Met.” Final worksheets are submitted to the SMA. The actual ratings are included in this report.

COMPLIANCE RATINGS

From January 2008 through June 2008, the MO HealthNet Managed Care Compliance Review Scoring Form for each health plan was updated to reflect their current level of MO HealthNet Managed Care contract compliance. The Scoring Form continued to present a crosswalk of contract references that created compliance with each federal regulation. The SMA instructed the EQRO to utilize the Compliance Rating System developed during the previous review. This system was based on a three-point scale (“Met,” Partially Met,” “Not Met”) for measuring compliance, as determined by the EQR analytic process.

Appendix 12 contains the BHC MO HealthNet Managed Care Compliance Review Scoring Form worksheet utilized for all health plans. The determinations found in the Compliance Ratings considered SMA contract compliance, review findings, health plan policy, ancillary documentation, and staff interview summary responses that validate health plan practices observed on-site. In some instances the SMA MO HealthNet Managed Care contract compliance tool rated a contract section as “Met” when policies were submitted, even if the policy had not been reviewed and “finally approved.” If the SMA considered the policy submission valid and rated it as “Met,” this rating was used unless practice or other information called this into question. If this conflict occurred, it

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was explained on the Compliance Review Scoring Form. The scale allowed for credit when a requirement was Partially Met. Ratings were defined as follows:

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Met:	All documentation listed under a regulatory provision, or one of its components was present. MO HealthNet Managed Care health plan staff was able to provide responses to reviewers that were consistent with one another and the available documentation. Evidence was found and could be established that the health plan was in full compliance with regulatory provisions.
Partially Met :	There was evidence of compliance with all documentation requirements, but staff was unable to consistently articulate processes during interviews; or documentation was incomplete or inconsistent with practice.
Not Met:	Incomplete documentation was present and staff had little to no knowledge of processes or issues addressed by the regulatory provision.

5.3 Findings

ENROLLEE RIGHTS AND PROTECTIONS

Subpart C of the regulatory provisions for Medicaid managed care (Enrollee Rights and Protections) sets forth 13 requirements of health plans for the provision of information to enrollees in an understandable form and language: written policies regarding enrollee rights and assurance that staff and contractors take them into account when providing services; and requirements for payment and no liability of payment for enrollees. There was only one item across all MO HealthNet Managed Care health plans that was rated as “Not Met” (see Table 42). Across all health plans 94.87% of the regulations were rated as “Met.” This is an overall improvement over the 90.77% “Met” rating in 2006 and significant improvement over the rate of 76.92% at the time of the 2005 EQR. Five of the health plans (Children’s Mercy Family Health Partners, Missouri Care, Mercy CarePlus, HealthCare USA and Blue-Advantage Plus) were found to be 100% compliant. One health plan (Harmony Health Plan) was rated as 69.2% “Met.” This is the first year that Harmony Health Plan is being rated for Compliance with the MO HealthNet Managed Care contract and the federal regulations. They have submitted required policy, and are in the process of completing the

approval process.



Table 42 – Subpart C: Enrollee Rights and Protections

Federal Regulation	MO HealthNet MCHP						All MO HealthNet MCHPs			
	MCP	Harmony	HCUSA	MOCare	CMFHP	BA+	Number Met	Number Partially Met	Number Not Met	Rate Met
438.100(a) Enrollee Rights: General Rule	2	2	2	2	2	2	6	0	0	100.0%
438.10(b) Enrollee Rights: Information Requirements	2	2	2	2	2	2	6	0	0	100.0%
438.10(c)(3) Alternative Language: Prevalent Language	2	2	2	2	2	2	6	0	0	100.0%
438.10(c)(4,5) Language and Format: Interpreter Services	2	2	2	2	2	2	6	0	0	100.0%
438.10(d)(1)(i) Information Requirements: Format/Easily Understood	2	2	2	2	2	2	6	0	0	100.0%
438.10(d)(1)(ii) and (2) Information Requirements: Format Visually Impaired, and Limited Reading Proficiency	2	2	2	2	2	2	6	0	0	100.0%
438.10(f) Information for All Enrollees: Free Choice, etc.	2	1	2	2	2	2	5	1	0	83.3%
438.10 (g) Information to Enrollees: Specifics/Physician Incentive Plans	2	2	2	2	2	2	6	0	0	100.0%
438.10(i) Special Rules: Liability for Payment/Cost Sharing	2	2	2	2	2	2	6	0	0	100.0%
438.100(b)(2)(iii) Enrollee Rights: Provider-Enrollee Communications	2	0	2	2	2	2	5	0	1	83.3%
438.100(b)(2)(iv,v) Rights to Refuse Services/Advance Directives	2	1	2	2	2	2	5	1	0	83.3%
438.100(b)(3) Right to Services	2	1	2	2	2	2	5	1	0	83.3%
438.100(d) Compliance with Other Federal/State Laws	2	2	2	2	2	2	6	0	0	100.0%
Number Met	13	9	13	13	13	13	74	3	1	94.87%
Number Partially Met	0	3	0	0	0	0				
Number Not Met	0	1	0	0	0	0				
Rate Met	100.0%	69.2%	100.0%	100.0%	100.0%	100.0%				

Note: 0 = Not Met; 1= Partially Met ; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCHPs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2007 External Quality Review Monitoring MCHPs Protocols.

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All health plans had procedures and practices in place to ensure that members: receive pertinent and approved information [438.100(a) and 438.10(b)]; were addressed in their prevalent language [438.10(c)(3)]; have access to required interpreter services [438.10(c)(4,5)]; that all information is provided in an easily understood format [438.10 (d)(1)(i)/438.10(d)(1)(ii) & (2)]; that members are treated with respect and dignity and receive information on available treatment options and alternatives [438.100(b)(2)(iii)/438.10(g)]; and the that the health plans are in compliance with other state requirements [438.100(d)].

A number of health plans (Children's Mercy Family Health Partners, Missouri Care, Mercy CarePlus, Blue-Advantage Plus, HealthCare USA) utilized EQR tools, including the MO HealthNet Managed Care Compliance Review Scoring Form, to assist them in ensuring completion of required policy as well as meeting the requirements of the federal regulations. Improvement was noted in the attention the majority of the health plans gave to meeting all standards of compliance. Tracking systems were put in place, and in some situations staff members were assigned to monitor compliance issues. The health plans stressed their heightened awareness of the need for positive interdepartmental communication. These efforts focused on strengthening communication to enhance the organizations' ability to serve members needs.

Two of the health plans (Children's Mercy Family Health Partners, Blue-Advantage Plus) utilized a Member Advisory Committee to provide insight into the issues faced by members in trying to obtain healthcare services. The health plans incorporated member suggestions into their operations and marketing materials. These activities were indicators of the health plans' commitment to member services and to ensuring that members have quality healthcare.

All health plans continued to operate programs for the provision of behavioral health services. Four of the health plans subcontract with Behavioral Health

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Organizations (BHO) for these services. Two health plans (Missouri Care, Harmony Health Plan) utilize an “in-house” model for the provision of behavioral health services. One of these plans (Missouri Care) does case management and maintenance of the provider delivery system within their health plan structure. One health plan (Harmony) utilized a subsidiary of their parent company to provide behavioral health services during 2007.

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All health plans provided active oversight, if not direct involvement, of their behavioral health subcontractors. Behavioral Health Services have evolved into an important resource for MO HealthNet Managed Care members. A majority of the health plans' subcontracted behavioral health partners (MHNet, Missouri Care, New Directions Behavioral Health, and Harmony Behavioral Health) approved the use of in-home services to reach members who would not attend appointments in an office setting. This not only ensured that members obtained the help they needed, but also prevented missed appointment for providers. One BHO (New Directions Behavioral Health) serves members from Children's Mercy Family Health Partners and Blue-Advantage Plus. This BHO continues to contract with a provider agency that delivered short-term intensive in-home services in an effort to avert crisis that may lead to inpatient treatment, and to work with members to utilize all available community resources. This service is available to both health plans. Two health plans (Mercy CarePlus, HealthCare USA) reported on initiatives to engage members who were pregnant, in an attempt to identify any mental health issues that might affect the mother and/or baby. These efforts also focused on prevention of postpartum depression. One health plan (Children's Mercy Family Health Partners) described an initiative where in-home services were provided to members following any inpatient treatment to ensure effective follow-up services. The BHO contracted with specific providers who were skilled at working in intensive in-home settings. The BHO absorbed the cost of unreimbursed services, such as after-hours telephone support, in an effort to reduce readmissions for these members. MO HealthNet Managed Care health plans and BHOs described a number of interventions that met members' needs, but were extraordinary in normal Medicaid programs. This reflected a level of performance indicative of their strong commitment to access and quality services for all members.

COMPLIANCE INTERVIEWS – MEMBER SERVICES STAFF AND CASE MANAGEMENT (BEHAVIORAL HEALTH)

Interviews were held at each health plan with Member Services Staff and Case Management Staff. Subsequently an interview occurred with Administrative Staff to obtain clarification on issues identified from the policy and document reviews, and additionally from the responses received from the front line staff interviews. Interview tools, developed from the questionnaires included in the Compliance Protocol, were developed for Customer Services Staff and Case Management staff (see Appendix 13).

The members of the customer service staff and the case managers interviewed exhibited a deep sense of commitment and professionalism when interacting with clients. The responses received reflected a thorough knowledge of each health plans policies and procedures. Member Services staff makes every effort to ensure that they provide MO HealthNet members with the information they need to make informed health care choices. They are trained to inform health plan members of the providers and services available and how to access these services. These health plan staff members are experienced in ensuring that MO HealthNet members have access to someone who speaks their language, or have access to a method of communication that enables them to obtain complete and thorough information. In most instances Member Services staff members gave concrete examples of assisting members by calling providers directly, immediately contacting case management staff to obtain assistance for a member, or made another contact to ensure that members received appropriate and timely health care.

Case Managers reported a clear understanding of the referral process and that the health plan had procedures in place to ensure that case managers received referrals from all sources. Case Managers described processes for contacting new referrals and the activities required for existing members cases. One health

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plan (Mercy CarePlus) refers all pregnant members for case management. The OB case managers discussed the referral sources, and the assessment process that ensures that members receive the types and frequency of services required. The case managers understand that accepting their services is a choice for members, but state that most members are willing to accept case management, although some do have reservations. If a health plan member refuses case management services initially, they can request these services at a future date. Treatment planning occurs with the member to ensure that they understand their service issues and additional assistance that will be provided. Providing a written copy of the treatment plan to health plan members did not occur regularly.

Case managers also described a methodology and provided concrete examples of coordination of care with behavioral health team members or Behavioral Health Organization (BHO) staff. They were also aware of the need to ensure that Primary Care Providers were involved when members were receiving both physical and mental health services.

Both case managers and member services staff were keenly aware of members' rights and responsibilities. These health plan staff members shared a commitment to providing services to members in the least restrictive environment and most respectful manner possible.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT: ACCESS STANDARDS

Subpart D of the regulatory provision for Medicaid managed care sets forth 17 regulations governing access to services. These regulations call for: the maintenance of a network of appropriate providers including specialists; the ability to access out-of-network services in certain circumstances; adequate

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care coordination for enrollees with special healthcare needs; development of a method for authorization of services, within prescribed timeframes; and the ability to access emergency and post-stabilization services. There were no items rated as “Not Met” (see Table 43). Across all MO HealthNet Managed Care health plans, 92.16% of the regulations were “Met,” which is a substantial improvement over the rate of 78.99% at the time of the 2005 EQR, but a slight decrease from the rate of 97.65% achieved in 2006. Five of the MCHPs (Children’s Mercy Family Health Partners, Blue-Advantage Plus, Mercy CarePlus, HealthCare USA, and Missouri Care) were found to be 100% compliant. One health plan (Harmony Health Care of Missouri) was rated as 52.9%. This is the first year that Harmony Health Plan is subjected to the full compliance review. They continue to be in the process of submission and approval of written policy and procedures with the SMA.

Table 43 – Subpart D: Quality Assessment and Performance Improvement: Access Standards

Federal Regulation	MO HealthNet MCHP						All MO HealthNet MCHPs			
	MCP	Harmony	HCUSA	MOCare	CMFHP	BA+	Number Met	Number Partially Met	Number Not Met	Rate Met
438.206(b)(1)(i-v) Availability of Services: Provider Network	2	1	2	2	2	2	5	1	0	83.3%
438.206 (b) (2) Access to Well Woman Care: Direct Access	2	1	2	2	2	2	5	1	0	83.3%
438.206(b)(3) Second Opinions	2	2	2	2	2	2	6	0	0	100.0%
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	2	2	2	2	2	2	6	0	0	100.0%
438.206(b)(5) Out of Network Services: Cost Sharing	2	2	2	2	2	2	6	0	0	100.0%
438.206(c)(1)(i-vi) Timely Access	2	2	2	2	2	2	6	0	0	100.0%
438.206(c)(2) Provider Services: Cultural Competency	2	2	2	2	2	2	6	0	0	100.0%
438.208(b) Care Coordination: Primary Care	2	1	2	2	2	2	5	1	0	83.3%
438.208(c)(1) Care Coordination: Identification	2	1	2	2	2	2	5	1	0	83.3%
438.208(c)(2) Care Coordination: Assessment	2	1	2	2	2	2	5	1	0	83.3%
438.208(c)(3) Care Coordination: Treatment Plans	2	1	2	2	2	2	5	1	0	83.3%
438.208(c)(4) Care Coordination: Direct Access to Specialists	2	1	2	2	2	2	5	1	0	83.3%
438.210(b) Authorization of Services	2	1	2	2	2	2	5	1	0	83.3%
438.210(c) Notice of Adverse Action	2	2	2	2	2	2	6	0	0	100.0%
438.210(d) Timeframes for Decisions, Expedited Authorizations	2	2	2	2	2	2	6	0	0	100.0%
438.210(e) Compensation of Utilization Management Activities	2	2	2	2	2	2	6	0	0	100.0%
438.114 Emergency and Post-Stabilization Services	2	2	2	2	2	2	6	0	0	100.0%
Number Met	17	9	17	17	17	17	94	8	0	92.16%
Number Partially Met	0	8	0	0	0	0				
Number Not Met	0	0	0	0	0	0				
Rate Met	100.0%	52.9%	100.0%	100.0%	100.0%	100.0%				

Note: 0 = Not Met; 1= Partially Met ; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCHPs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2007 External Quality Review Monitoring MCHPs Protocols.

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All MO HealthNet Managed Care health plans had policies and practice that reflected the members' right to a second opinion and a third opinion if the first two disagreed [438.206(b)(3)]. Other areas where all health plans were 100% compliant with complete and approved policy were Adequate and Timely Service and Cost Sharing for Out of Network Services; Timely Access to Care, Provider Cultural Competency; Timeframes for Decisions for Expedited Authorizations, Utilization Management Activities, and Emergency and Post-Stabilization Services. Throughout this review period, all health plans reported incidents where they found providers who were familiar with members' cultural and language needs. Sensitivity to and respect for members' cultural needs was an area where the health plans excelled. All health plans were fully compliant in having SMA approved notifications of adverse actions [438.210(c)]. There were no identified incidents of incentivizing staff or contractors for utilization management decisions that were in the favor of the MO HealthNet Managed Care health plans. All policies and practices in this area [438.210(e)] were compliant.

The area of access to care was a primary focus of improvement for all the health plans during 2007. Evidence existed of efforts to inform members of available providers, urgent care centers, and hospitals through presentations at community events and newsletters. The need to ensure that members received appropriate referrals to PCPs and specialty providers was clearly reflected in Member Service Staff and Case Management interviews. Required documentation and approved policies did exist in all areas for all health plans but one (Harmony Health Plan of Missouri). Five of the MO HealthNet Managed Care health plans (Mercy CarePlus, HealthCare USA, Missouri Care, Children's Mercy Family Health Partners, and Blue-Advantage Plus) had complete policy and practices, and Provider Manual language in the area of emergency and post-stabilization services [438.114]. One MO HealthNet Managed Care health plan (Harmony Health Plan of Missouri) continues to have policy under review

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awaiting final approval by the SMA. The health plans made efforts to ensure that the problems they experienced did not affect services to members. All health plans provided evidence of strong relationships with their providers and maintained strong communication with them particularly in solving member service problems. Harmony Health Plan reported that they are continuing active recruitment efforts in the outlying counties in the region. However, their network has improved in all areas during the past year of operation.

The health plans made a concerted effort to ensure that members had appropriate and timely access to services. They continued to express concern over the shortage of specialists in the areas of orthopedic surgery, pediatric neurology, rheumatology, and child/adolescent psychiatrists. All health plans reported utilizing out-of-network providers and often paying commercial or higher rates to obtain these services. One health plan (Children's Mercy Family Health Partners) had a number of specialists who requested that they not be included on the MO HealthNet MCHP's published network, but readily agreed to service members, when requested, at the MO HealthCare Managed Care rate. A number of the health plans (HealthCare USA, Missouri Care) continued to partner with teaching hospitals in their Regions, in order to increase their available surgical and specialist capacity. All health plans had an internal system that could provide specialist services, even in specialties that were normally difficult to access, when required to meet members' healthcare needs.

All health plans exhibited a deep commitment to delivering and providing oversight of behavioral health services. One health plan (Missouri Care) no longer uses a subcontracted network for behavioral health. This health plan recognized a number of advantages in directly supervising the provision of behavioral health services. They contracted with the majority of the active providers previously utilized by the subcontractor. They were able to recruit additional providers through the use of solo practices, particularly those who

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provided in-home treatment services. They maintained the same toll-free telephone number for member access, and conducted provider training. Some of the benefits identified included: reducing the use of inpatient treatment; more timely and complete prior authorizations; and improved case management, particularly for members who require both physical and mental health treatment. They did experience some difficulties in motivating the smaller providers to comply with timely claims submission requirements, but through training are seeing improvements in this area. This health plan's case managers also reported that communicating with behavioral health case managers, and coordinating services between behavioral health providers and PCPs improved with this new service delivery system.

MEMBER SERVICE STAFF AND CASE MANAGER INTERVIEWS

Member Services and Case Management staff both reflected that one of the key aspects of their role is ensuring the members receive proper health care is ensuring adequate access to health care. These staff members report that they answer many questions regarding identification of PCPs and their address, assisting in changing PCPs for new members particularly if an auto-assignment occurred, and in ensuring that members receive timely appointments. These staff also assists members in identifying and obtaining appointments with specialists. They respond to questions about authorization for services, and assist members in finding physicians who meet members' cultural and language needs. These staff members were animated in their discussion about finding the best physician or medical provider for health plan members with special needs. Their responses reflected a sincere desire to assist members in their access to care issues, and a sense of accomplishment when this occurred in a timely and efficient manner.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT: STRUCTURE AND OPERATION STANDARDS

There are 10 Structure and Operations Standards for ensuring compliance with State policies and procedures for the selection and retention of providers, disenrollment of members, and accountability for activities delegated to subcontractors. There were no items across MO HealthNet Managed Care health plans that were rated as "Not Met." Across MO HealthNet Managed Care health plans, 95% of the regulations were "Met," which is an improvement over the rating of 88.6% from the 2005 EQR and a decrease from 2006 when health plans achieved a rate of 98% compliance in this area (see Table 44).

Table 44 – Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards

Federal Regulation	MO HealthNet MCHP						All MO HealthNet MCHPs			
	CCP	Harmony	HCUSA	MOCare	CMFHP	BA+	Number Met	Number Partially Met	Number Not Met	Rate Met
438.214(a,b) Provider Selection: Credentialing/Recredentialing	2	1	2	2	2	2	5	1	0	83.3%
438.214(c) and 438.12 Provider Selection: Nondiscrimination	2	1	2	2	2	2	5	1	0	83.3%
438.214(d) Provider Selection: Excluded Providers	2	2	2	2	2	2	6	0	0	100.0%
438.214(e) Provider Selection: State Requirements	2	2	2	2	2	2	6	0	0	100.0%
438.226 and 438.56(b)(1-3) Disenrollment: Requirements and limitations	2	2	2	2	2	2	6	0	0	100.0%
438.56(c) Disenrollment Requested by the Enrollee	2	2	2	2	2	2	6	0	0	100.0%
438.56(d) Disenrollment: Procedures	2	2	2	2	2	2	6	0	0	100.0%
438.56(e) Disenrollment: Timeframes	2	2	2	2	2	2	6	0	0	100.0%
438.228 Grievance System	2	1	2	2	2	2	5	1	0	83.3%
438.230(a,b) Subcontractual Relationships and Delegation	2	2	2	2	2	2	6	0	0	100.0%
Number Met	10	7	10	10	10	10	57	3	0	95.0%
Number Partially Met	0	3	0	0	0	0				
Number Not Met	0	0	0	0	0	0				
Rate Met	100.0%	70.0%	100.0%	100.0%	100.0%	100.0%				

Note: 0 = Not Met; 1= Partially Met ; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCHPs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2007 External Quality Review Monitoring MCHPs Protocols.

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The Provider Services departments of all MO HealthNet Managed Care health plans exhibited a sound and thorough understanding of the requirements for provider selection, credentialing, nondiscrimination, exclusion, and MO HealthNet Managed Care requirements. Five of the MO HealthNet Managed Care health plans (Children's Mercy Family Health Partners, Blue-Advantage Plus, Missouri Care, Mercy CarePlus and HealthCare USA) were 100% compliant with all regulations. The final health plan (Harmony Health Plan of Missouri) met 70% of the regulations. Seven of the individual regulations were 100% met. This included Provider Selection [438.214(d) and 438.214(e)]. The staff at each health plan understood the requirements for disenrollment. They were 100% "Met" for the applicable regulations for timeframes [438.56(e)]. All of the health plans met all regulations for disenrollment procedures. Five of the health plans (83.3%; Children's Mercy Family Health Partners, Blue-Advantage Plus, Missouri Care, Mercy CarePlus and HealthCare USA) had appropriate grievance systems in place that met the requirements of this regulation [438.228]. Two of the health plans (HealthCare USA, and Blue-Advantage Plus) described credentialing and re-credentialing policies that exceeded the requirements of the regulations. Providers were willing to submit to these stricter standards to maintain network qualifications in both the health plans and other commercial networks. Overall, five (83.3%) of the health plans had all required policies and practices in place regarding credentialing. One health plan (Harmony Health Plan of Missouri) continued to have outstanding policy in the area of credentialing, non-discrimination and sub-contractual relationships (438.214 (a,b)/438.214(c)/438.230)(a,b).

All health plans understood the required oversight of subcontractors. The compliance rate for this regulation [438.230(a,b)] improved from the 2005 rate of 71.4%, to the 2007 rate of 83.3%.

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All previous deficiencies for Structure and Operation Standards related to a lack of submitted or approved policies or subcontractor agreements. The health plans exhibited a significantly improved understanding and attention to these details and requirements during this review. Interviews revealed that Member Services staff quickly identifies problems if they receive calls related to these issues. However, it is their responsibility to refer these issues and questions to the provider services staff as quickly as possible. The Member Services staff make notes of all of their telephone contacts in the health plans' internal systems and make appropriate referrals. These processes were described in detail and are clearly understood by the staff involved.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT: MEASUREMENT AND IMPROVEMENT

There are 12 Measurement and Improvement Standards addressing the selection, dissemination, and adherence to practice guidelines; the implementation of performance improvement projects; the calculation of performance measures; the evaluation of the availability of services and assessment techniques for enrollees with special healthcare needs; and the maintenance of information systems that can be effectively used to examine service utilization, grievances and appeals, and disenrollment. All items were either “Met” or “Partially Met” for compliance with Measurement and Improvement (see Table 44). A total of 89.4% of the criteria were “Met” by the MO HealthNet Managed Care health plans, which continues to indicate improvement in meeting federal requirements, over the 2005 rate of 83.1%. However, this is a decrease from the rate of 98.2% achieved in 2006. This number again reflects that one health plan (Harmony Health Care of Missouri) is continuing to submit policy for SMA approval. Five health plans (Missouri Care, Children’s Mercy Family Health Partners, Mercy CarePlus, HealthCare USA, and Blue-Advantage Plus) met all the requirements (100%) in this area.

Table 45 – Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement

Federal Regulation	MO HealthNet MCHP						All MO HealthNet MCHPs			
	MCP	Harmony	HCUSA	MOCare	CMFHP	BA+	Number Met	Number Partially Met	Number Not Met	Rate Met
438.236(b)(1-4) Practice Guidelines: Adoption	2	2	2	2	2	2	6	0	0	100.0%
438.236(c) Practice Guidelines: Dissemination	2	2	2	2	2	2	6	0	0	100.0%
438.236(d) Practice Guidelines: Application	2	2	2	2	2	2	6	0	0	100.0%
438.240(a)(1) QAPI: General Rules	2	1	2	2	2	2	5	1	0	83.3%
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCHP Quality Improvement and PIPs	2	1	2	2	2	2	5	1	0	83.3%
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	2	2	2	2	2	2	6	0	0	100.0%
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	2	1	2	2	2	2	5	1	0	83.3%
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	2	1	2	2	2	2	5	1	0	83.3%
438.240(e) QAPI: Program Review by State	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
438.242(a) Health Information Systems	2	1	2	2	2	2	5	1	0	83.3%
438.242(b)(1,2) Health Information Systems: Basic Elements	2	1	2	2	2	2	5	1	0	83.3%
438.242(b)(3) Health Information Systems: Basic Elements	2	1	2	2	2	2	5	1	0	83.3%
Number Met	11	4	11	11	11	11	59	7	0	89.4%
Number Partially Met	0	7	0	0	0	0				
Number Not Met	0	0	0	0	0	0				
Rate Met	100.0%	36.4%	100.0%	100.0%	100.0%	100.0%				

Note: Regulation 438.240(e) refers to program review by the state. The regulation requires the state to review, at least annually, the impact and effectiveness of each MCHP's quality assessment and performance improvement program. The regulation refers to the state QA & I program review process and is not applicable to External Quality Review of the MO HealthNet Managed Care Program. This percent is calculated for the regulations that are applicable to the MO HealthNet Managed Care Program.

0 = Not Met; 1 = Partially Met ; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCHPs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2007 External Quality Review Monitoring MCHPs Protocols.

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During previous reviews the area of practice guidelines was problematic for two health plans (Mercy CarePlus and HealthCare USA). Both had relatively new Medical Directors, who identified resistance on the part of the medical community in the St. Louis area to the acceptance or implementation of practice guidelines. The specific requirements of the regulations were related to both health plans. Both of these health plans improved in this area during the 2007 review. They have practice guidelines in place and are monitoring providers to ensure their utilization. Currently all six of the health plans (100%) met all the requirements for adopting, disseminating and applying practice guidelines. In the Western Region, staff from the health plans meets with a quality enhancement group in the healthcare community (Kansas City Quality Improvement Consortium). Regional standards and practices were discussed and regionally specific standards, that met or exceeded nationally accepted guidelines, were developed. All health plans related that they expected providers to use the practice guidelines combined with their experience and patient knowledge in their decision-making. When conflicts occurred, the Medical Director reviewed the situation and consulted with the provider in an effort to ensure that the services that were provided were in the members' best interest.

Five of the health plans (83.3%) used nationally accredited criteria for utilization management decisions [438.240(b)(3)]. The tools the health plans reported using included the InterQual Clinical Decision Support Tool, LOCUS/CALOCUS (Level of Care Utilization System/Child and Adolescent Level of Care Utilization System) for utilization management decisions in the provision of behavioral health services and the Milliman Care Guidelines. These sources provided evidence-based criteria and best practice guidelines for healthcare decision-making. The health plan staff was able to articulate how they utilized these tools and apply them to member healthcare management issues. The MO HealthNet Managed Care health plans used all information available to them to ensure that evidence-

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based practice ensuring member safety while controlling medically unnecessary care. During the Member Services and Case Management interviews, staff was asked about members' knowledge of or requests for practice guidelines. One health plan (Mercy CarePlus) reported one incident of a mother who is an RN requesting copies of the Asthma practice guidelines prior to attending her child's health care appointment. This parent was aware of the guidelines and wanted to ensure that her child received the best treatment. Other health plans (Blue-Advantage Plus, Children's Mercy Family Health Partners) reported that members haven't actually requested practice guidelines, but have requested treatment procedures, particularly in the instance of member with asthma. Members were provided with this information that assisted in ensuring that their children obtained appropriate levels of information.

The health plans were actively involved in developing and improving their Quality Assessment and Improvement Programs. Two of the health plans (Blue-Advantage Plus, Children's Mercy Family Health Partners) utilized community based advisory boards, one of which (Children's Mercy Family Health Partners) included members. These groups assisted the health plans in assessing member needs and barriers to services. Both health plans utilized the recommendations of these groups in their operations, member information, and daily activities. All of the health plans developed internal systems for monitoring, analysis and evaluation of their own programs. Five (83.3%) had a program and all required policy and procedures in place to meet the requirements of the federal regulations [438.240(a)(1)]. Harmony Health Plan of Missouri continues working with the SMA on submission and approval of all required policy.

All health plans' compliance improved in the section of the protocol involving Validating Performance Improvement Projects, Validating Performance Measures, Validating Encounter Data, and Health Information Systems. Detailed findings and conclusions for these items are provided in previous sections of this

report and within the MO HealthNet Managed Care health plan summaries.



GRIEVANCE SYSTEMS

Subpart F of the regulatory provisions for Medicaid managed care (Grievances and Appeals) sets forth 18 requirements for notice of action in specific language and format requirements for communication with members, providers and subcontractors regarding grievance and appeal procedures and timelines available to enrollees and providers. Five of the six health plans excelled (100%) in their compliance with the regulations related to grievances and appeals (see Table 46). There were no items rated as “Not Met.” These five health plans (Mercy CarePlus, HealthCare USA, Children’s Mercy Family Health Partners, Missouri Care, and Blue-Advantage Plus) were found 100% in completing required policy, procedure, and practice in their Grievance Systems.

One health plan (Harmony Health Care of Missouri) continued to have policy and procedures that required approval by the SMA. The six health plans overall score for this section is 84.3%. This number reflects that Harmony Health Plan of Missouri has not completed the policy submission and approval process.

Table 46 – Subpart F: Grievance Systems

Federal Regulation	MO HealthNet MCHP						All MO HealthNet MCHPs			
	MCP	Harmony	HCUSA	MOCare	FHP	BA+	Number Met	Number Partially Met	Number Not Met	Rate Met
438.402(a) Grievance and Appeals: General Requirements	2	1	2	2	2	2	5	1	0	83.3%
438.402(b)(1) Grievance System: Filing Requirements - Authority	2	1	2	2	2	2	5	1	0	83.3%
438.402(b)(2) Grievance System: Filing Requirements - Timing	2	1	2	2	2	2	5	1	0	83.3%
438.402(b)(3) Grievance System: Filing Requirements - Procedures	2	1	2	2	2	2	5	1	0	83.3%
438.404(a) Grievance System: Notice of Action - Language and Format	2	1	2	2	2	2	5	1	0	83.3%
438.404(b) Notice of Action: Content	2	1	2	2	2	2	5	1	0	83.3%
438.404(c) Notice of Action: Timing	2	1	2	2	2	2	5	1	0	83.3%
438.406(a) Handling of Grievances and Appeals: General Requirements	2	1	2	2	2	2	5	1	0	83.3%
438.406(b) Handling of Grievance and Appeals: Special Requirements for Appeals	2	1	2	2	2	2	5	1	0	83.3%
438.408(a) Resolution and Notification: Basic Rule	2	1	2	2	2	2	5	1	0	83.3%
438.408(b,c) Resolution and Notification: Grievances and Appeals - Timeframes and Extensions	2	1	2	2	2	2	5	1	0	83.3%
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	2	1	2	2	2	2	5	1	0	83.3%
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	2	2	2	2	2	2	6	0	0	100.0%
438.410 Expedited Resolution of Appeals	2	1	2	2	2	2	5	1	0	83.3%
438.414 Information about the Grievance System to Providers and Subcontractors	2	1	2	2	2	2	5	1	0	83.3%
438.416 Recordkeeping and Reporting Requirements	2	1	2	2	2	2	5	1	0	83.3%
438.420 Continuation of Benefits while Appeal/Fair Hearing Pend	2	1	2	2	2	2	5	1	0	83.3%
438.424 Effectuation of Reversed Appeal Resolutions	2	1	2	2	2	2	5	1	0	83.3%
Number Met	18	1	18	18	18	18	91	17	0	84.3%
Number Partially Met	0	17	0	0	0	0				
Number Not Met	0	0	0	0	0	0				
Rate Met	100.0%	5.6%	100.0%	100.0%	100.0%	100.0%				

Note: 0 = Not Met; 1 = Partially Met ; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCHPs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2007 External Quality Review Monitoring MCHPs Protocols.

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Grievance and Appeal reports for both members and providers were reviewed for 2007, as submitted to the SMA. The health plans reported different numbers and types of concerns. The number of member grievances and appeals varied between the health plans. However, the numbers were proportional to health plan enrollment. Provider complaints, grievances, and appeals also varied but were not disproportional to the provider network.

In analyzing the Grievance System report, the most frequent issues included:

Member - Grievances and Appeals	Provider – Complaints, Grievances, and Appeals
<ul style="list-style-type: none"> • Transportation • Prescription Drug Issues • Appointment Availability/Continuity of Treatment • Treatment by Provider/Staff • Service Category/Prior Auth. (denial) • Claims Issue/Uncovered Benefit • Inability to Find PCP/Specialist – or Obtain an Appointment • State Fair Hearing Request 	<ul style="list-style-type: none"> • Authorizations – Denied/Late/None • Billing Problems • Contractual Issues • Untimely Submission of Claims • Uncovered Benefit • Additional Information Required • Medical Necessity Question

The largest number of member grievance/appeals continued to concern transportation issues. The largest number of provider complaints/grievances/appeals continued to include authorization issues and untimely submission of claims. The majority of the claims were the result of payment disputes, although a number of grievances and appeals filed by providers did dispute decisions that appeared to affect the quality of care received by members.

There were no deficiencies in the Grievance System policy submission for five of the six health plans. The health plans are diligent in maintaining policies and practices in this area to ensure that these systems are up-to-date and comply with the SMA contract requirements and federal regulations. Appropriate practice for addressing member grievance and appeals, and provider complaints, grievances and appeals appeared to be in place for all health

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plans.

Interview results reflect that the health plans have specific units or persons who respond to member grievances and appeals and provider complaints grievances and appeals. Member Services staff are often the first individuals to hear about issues that members have with either providers or with the health plan itself. They assist the member in making an informed decision about filing a grievance or appeal, and they refer the issue to the appropriate person or unit in their health plan. They do not process grievances or appeals for members. However, most plans described a case management system where the number and type of cases or issues are reflected in the notes that staff record on all member contacts. These processes are resulting in timely processing of the complaints, grievances and appeals. Staff is aware that it is the member's decision to file a grievance or appeal. However, they record their conversations regardless of the choices made. Staff states that if a member chooses not to file a grievance or appeal, and it appears that the health plan or a provider had an issue with a member, they send these notes on to the Grievance and Appeal Unit, and/or to Provider Services for follow-up to ensure that all issues are resolved.

5.4 Conclusions

Across all MO HealthNet Managed Care health plans there was a substantial improvement in the area of compliance with federal regulations. There was only one regulations rated as "Not Met." All other individual regulations were rated as "Met" or "Partially Met." Five of the health plans were 100% compliant with all requirements. The remaining health plan was only 5.6% compliant with the regulations related to Grievances; 69.2% compliant with Enrollee Rights and

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Protections; 52.9% compliant with Access Standards; 70% compliance with Structure and Operations; and 36.4% compliant with Measurement and Improvement. With the exception of one health plan, which is in the process of completing their first compliance review, this indicates significant improvement in becoming compliant with the State SMA contractual requirements and the corresponding federal regulations over the 2006 EQR. All sources of available documentation, interviews, and observations at the on-site review were used to develop the ratings for compliance. The EQRO comments were developed based on review of this documentation and interview responses. Several of the health plans made it clear that they used the results of the prior EQR to complete and guide required changes. One health plan (Mercy CarePlus) significantly improved and stated that they utilized the compliance protocol as a tool to develop their performance and improve services to members. This health plan achieved improved compliance to 100% in every category. The following summarizes the strengths in the areas of Access to Care, Quality of Care and Timeliness of Care.

Recommendations are based on the findings utilizing the Protocol for Determining Compliance with Medicaid Managed Care Regulations.

QUALITY OF CARE

Eight of the 13 regulations for Enrollee Rights and Protections were 100% “Met.” Communicating MO HealthNet Managed Care Members’ rights to respect, privacy, and treatment options, as well as communicating, orally and in writing, in their own language or with the provision of interpretive services is an area of strength for all health plans. The MO HealthNet Managed Care health plans communicated that meeting these requirements with members and providers, created an atmosphere with the expectation of delivering quality healthcare. The health plans maintained an awareness of and appropriate responses to cultural and language barriers concerning communication in obtaining

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healthcare. The health plans responded to physical, emotional and cultural barriers experienced by members with diligence and creativity. The health plans were aware of their need to provide quality services to members in a timely and effective manner.

Seven of the 10 regulations for Structure and Operations Standards were 100% “Met.” These included provider selection, and network maintenance, subcontractual relationships, and delegation. The health plans had active mechanisms for oversight of all subcontractors in place. All health plans improved significantly in compliance with this set of regulations and articulated their understanding that maintaining compliance in this area enabled them to provide quality services to their MO HealthNet Managed Care Members.

ACCESS TO CARE

Five of the MO HealthNet Managed Care health plans were fully compliant with the 17 federal regulations concerning Access Standards. These included: provider networks; freedom of choice and access to all services; out-of-network services; timely access to care; core coordination; authorization of services; appropriate notifications; timeliness of decisions regarding care and emergency and post-stabilization services. The six MO HealthNet Managed Care health plans monitored high risk MO HealthNet Managed Care Members and had active case management services in place. Each health plan described measures they used to identify and provide services to MO HealthNet Managed Care Members who have special healthcare needs. Many of these case management programs exceeded the strict requirements in the MO HealthNet Managed Care contract. All six health plans could describe efforts to participate in community events and forums to provide education to members regarding the use of PCPs, special programs available, and how to access their

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PCP and other specialist service providers that might be required. The health plans were crucially aware of their responsibility to provide access to care and services, and to communicate complete information on this topic to their members.

TIMELINESS OF CARE

Four of the 12 regulations for Measurement and Improvement were 100% “Met.” Five of the six MO HealthNet Managed Care health plans met all of the regulatory requirements. All six health plans adopted, disseminated and applied practice guidelines to ensure sound and timely healthcare services for members. The health plans used their health information systems to examine the appropriate utilization of care using national standard guidelines for utilization management. The health plans were beginning to utilize the data and demographics in their systems to track and trend information on members to assist in determinations of risk and prevention initiatives. Several health plans began using member and community based quality improvement groups to assist in determining barriers to services and methods to improve service delivery. The Member Services and Case Management departments had integral working relationships with the Provider Services and Relations Departments of the health plans. All front line staff and administrators interviewed exhibited a commitment to relationship building, as well as monitoring providers to ensure that all standards of care were met and that good service, decision-making, and sound healthcare practices occurred on behalf of health plan members. The health plans all provided examples of how these relationships served to ensure that members received timely and effective healthcare. The health plan staff would contact providers directly to make appointments whenever members expressed difficulty in obtaining timely services.

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All 18 regulations for Grievance Systems were 100% “Met” for five of the health plans. One health plan (Harmony Health Care of Missouri) continues to work toward completion of adequate and approved policy with the SMA. The five remaining health plans were 100% compliant with the requirements for policy, procedure and practice in the area of Grievance Systems. The health plans provided examples of how timely decision-making allowed members to obtain their healthcare quickly and in the most appropriate setting. The health plans understood that maintaining this system was an essential component to ensuring timely access to healthcare.

MO HealthNet Managed Care health plans remained invested in developing programs and providing services beyond the strict obligations of the contracts. Preventive health and screening initiatives exhibited a commitment to providing the best healthcare in the least invasive manner to their members. Partnerships with local universities and medical schools provided opportunities to obtain cutting-edge and occasionally experimental treatment options, which would not otherwise be available to members. The health plans observed that these efforts combined to create a system that allowed members timely access to quality healthcare.

RECOMMENDATIONS

1. Continue to distribute the completed compliance tools to the health plans to ensure recognition of the policies and procedures that must be completed and approved to achieve compliance with federal regulations.
2. MO HealthNet Managed Care health plans must continue to recognize the need for timely submission of all required policy and procedures. The majority of the health plans put a tracking or monitoring system into place

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- to ensure timely submission of documentation requiring annual approval. These systems must be maintained to ensure that this process remains a priority for all health plans
3. MO HealthNet Managed Care health plans identified the need for continuing to monitor provider availability in their own networks. Although most health plans had the number of primary care providers (PCPs) and specialists required to operate, they admitted that many of these PCPs had closed panels and would not accept new patients. Ensuring that there is adequate access for all members, including new members, should be a priority for all health plans.
 4. MO HealthNet Managed Care health plans identified improvement in their Quality Assessment and Improvement programs, and how this enhanced their ability to provide adequate and effective services to members. These efforts must be relentlessly continued to ensure that the organizations remain aware of areas for growth and improvement. These efforts ensure that the quality, timeliness and access to care required for member services is maintained at an exceptional health plans continued to struggle with recruitment of certain specialty physicians.
 5. MO HealthNet Managed Care health plans identified the need for additional dental providers. Recruitment was largely delegated to subcontractors. Becoming actively involved in recruitment activities would benefit members and improve the quality of and access to care.
 6. The use of data for quality improvement purposes and examination of healthcare outcomes has increased dramatically. Continued growth in the utilization of all of the data available to drive healthcare practice and initiatives is required to improve quality and access to care.



6.0 Blue-Advantage Plus of Kansas City

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The remaining sections of the 2007 EQRO report summarize health plan specific methods, procedures, findings, and recommendations for improving the quality, timeliness, and access to care for the MO HealthNet Managed Care Health Plan members. Please refer to the main report for detailed technical objectives, methods and presentation of data that are referenced here for each MO HealthNet Managed Care Health Plan.



6.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

Blue-Advantage Plus supplied the following documentation for review:

- NCQA Quality Improvement Activity Form: Ambulatory Follow-Up after Hospitalization for Mental Health Disorders for BA+ Members
- NCQA Quality Improvement Activity Form: Training Education and Restructuring the Work Flow of Member Grievances and Appeals, and Provider Complaints, Grievances, and Appeals to Improve the Response Time to Members and Providers.

INTERVIEWS

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on July 23, 2008 during the on-site review at the Kansas City, Missouri offices. Interviews included the following:

Judy Brennan – Director State Programs BA+, Plan Administrator
Wes Wadman – Special Programs Coordinator
Tylisha Wyatt – Complaint Analyst
Cheryl Banks – Manager, Quality Performance Measurement
Lisa Woodring – Senior Director, Care Management NDBH
Don Howard – New Directions Behavioral Health
Garth Smith – New Directions Behavioral Health
Shelly Bowen – Assistant Vice President Quality Management

Interviewees shared information on the validation methods, study design, and findings. Technical assistance regarding study design and presentation of findings was provided by the EQRO. The following questions were addressed:

- What study questions were used?
- What instruments were used for data collection?
- How were the accuracy, consistency, and validity assured?
- What interview instruments were used?
- Why were the projects valid for continuation and used as PIPs for this project year?
- What findings were relevant to the MO HealthNet managed care population?
- How was improvement analyzed?
- What are the conclusions about the effectiveness of the interventions analyzed?

Several questions were presented during the on-site review and the health plan requested time to provide additional information. This information was received and considered in the final validation process.

FINDINGS

The first PIP evaluated was Ambulatory Follow-Up after Hospitalization for Mental Health Disorders for BA+ Members. This project was submitted as a clinical performance improvement project. This clinical project focused on improving the number of members who complied with the HEDIS measure requiring follow-up services within seven (7) and thirty (30) days after hospitalization. The health plan identified this as a problem based on the results of their prior years' HEDIS reviews. Revised information provided the basis for making the choice to embark on this project. This decision was based on HEDIS/NCQA standards and the literature review supporting the importance of compliance with timely follow-up care in reducing the risk of readmission to inpatient mental health treatment services. The study rationale is not fully developed integrating local issues and the study research sited.

The study choice is supported as a relevant area of clinical care. How the study

relates to issues relevant to Blue-Advantage Plus members is not well defined. This may meet the requirements for an NCQA study. It does not meet the EQR protocol requirements. All enrollees between the ages of six and 65 were included in this study. No members were excluded based on the need for special healthcare services. Why this population is specified is not delineated in the narrative.

The study question submitted was, "Will follow-up care and coordination with members who are discharged from inpatient care increase the rate of follow-up through ambulatory appointments within seven and 30 days." The concept of follow-up care and coordination is not described in a measurable terminology. However, in the study indicators, these measures are defined. Baseline information and goals for achievement are not presented. It should be noted that the health plan states that they use a HEDIS-like measurement methodology. The measurements are based on and defined by the HEDIS requirement; however, they are collected quarterly allowing for obtaining data more frequently and meeting protocol standards.

The study did present clearly defined indicators that were measurable. Information provided defined the numerators and denominators that would be used to calculate success. The indicators were directly based on the HEDIS methodology. Due to inconsistencies in obtaining HEDIS data from the Behavioral Health Organization, or subcontractor providing these services, a "HEDIS-like" measurement was developed to compare to the actual HEDIS statistics gathered. The HEDIS-like measure utilized the technical specifications of what and how to measure the follow-up rates. The data from this quarterly measure will be analyzed and compared to the actual certified HEDIS data when it becomes available on an annual basis. Detailed demographic characteristics were presented in the narrative. The documentation noted that no portion of the population was excluded from the study. The focus of this study includes Blue-Advantage Plus members only. The indicators measured the occurrence of timely adherence to aftercare plans.

The population included in the study are all members, ages 6 through 65 with a HEDIS qualifying diagnosis, discharged from inpatient psychiatric treatment during each study year. The health plan used the HEDIS specifications in defining this population. No sampling was used to determine who would be included.

The data sources described were specific. The additional information received

explained the methodology for data collection. The sources of data included claims and encounter data that are sampled on a yearly basis. Quarterly runs were also to occur and were updated in each consecutive quarter. The details of these sources were provided with adequate detail to produce confidence in their reliability and validity. The methodology remained constant across all time periods studied. The data included information exclusive to MO HealthNet managed care members.

The data collection and analysis plans included a detailed definition regarding how the HEDIS and HEDIS-like methodologies were to be used for internal monitoring of the follow-up service compliance. This explanation includes a narrative explanation of the case management process to be employed to improve this measure. An in-depth data analysis plan was detailed in the documentation including a plan for quantitative and qualitative analysis. This plan provided information on how results would be presented and compared.

The information provided did include data representing the baseline data, 1/1/05 through 12/31/05, for each intervention, and the results of one follow-up period, which was 1/1/06 through 12/31/06. HEDIS-like data was included for the periods from 01/01/07 to 09/30/07. Improvement was identified although the stated goals of the project and comparison benchmarks were not met throughout this period.

The interventions utilized and the barriers to success were documented in great detail. Interventions, barriers, and opportunities for improvement were included for both facility issues and member issues. A discussion of methods or plans to improve or enhance these interventions to obtain a more successful outcome was not included. The information included did provide confidence that this project could have substantive impact on members compliance with obtaining the follow-up care required after a hospitalization for mental health services.

The second PIP evaluated was “Appeals Process Compliance Performance Improvement Project.” This was a non-clinical project. The decision to choose this study topic was supported by information provided regarding the MO HealthNet Managed Care Organization compliance with SMA contract requirements. The rationale presented was thorough and clearly based on the need to respond to member grievance and appeal requests in a timely fashion. The argument was presented that responding to grievance and appeals issues timely and efficiently decreased the delay in access to care. The need for

improvement was explained in the narrative and was supported by review of MO HealthNet Managed Care health plan prioritized performance expectations and the results of the actual performance in this area. The narrative information effectively made the argument that this non-clinical approach to a performance improvement project was focused on improving the key aspects of member services.

The information supporting this PIP stated that “by improving the response time of member grievances and appeals, and provider complaints, grievances, and appeals. It provides the opportunity for the members and providers to make timelier health care decisions.”

The study question for this project was, “Will reviewing and revising the workflow and processes of complaints management, and educating appropriate staff, improve the complaints response time to members and providers?” The study question is well constructed and conveys the intent of the project. The indicators were discussed in detail and were based on the factors that created compliance for closing member grievances and appeals, or provider complaints, grievances and appeals within the required timeframe as included in the SMA contract. The goal was to obtain 100% compliance for each of the six indicators included in this project. The indicators were constructed to measure timely resolution for each step in the grievance and appeal process. The narrative did associate this goal with improved member outcomes. The population includes all members and providers who file grievances and appeals. No group of the member population is excluded.

The study design specified what data is to be collected and how this will occur. The health plan will use information generated by their FACETS system. This system includes the utilization management aspect of the health plan responsibilities. It also generates and tracks information to health plan staff, including the required Notice of Action letters. This system provides quick access to member information. The information provided ensured that all data in this system was valid and reliable. The FACETS database created quarterly reports on the indicators, including dates, reason, and notice of action outcomes.

A baseline methodology was provided and included pertinent measures for each indicator. A detailed data analysis plan was part of this documentation. This plan explained all data to be extracted from FACETS, and how it would be

entered into tables to document numerator and denominators. Statistical testing for each measurement period was described. The z test will be utilized in compiling the results from this project. The narrative included a description of the quantitative and qualitative analysis conducted as part of the study process.

Interventions described included:

- training for subcontractors, customer service staff, and state program staff;
- the development of desk references for procedures and requirements; and
- management training regarding the timeframes and requirements of the NOA letters.

A description of the barriers to success was provided. Causes and possible solutions were also described.

The findings for one year post baseline were included. A detailed analysis of the data was provided in the narrative. The analysis described the measures where the goals were met, and those that indicated improvement, but had not yet reached the desired outcome. This analysis provided a discussion about barriers in reaching the desired goals. Enhancements to improve these interventions were also described. The analysis identified initial and repeat measurements, statistical significance, and internal and external validity.

This study has potential for producing credible findings. The four re-measurement cycles included in the information presented covered the first year post baseline, and three quarters in the following year using HEDIS-Like measures, in which these interventions were implemented. The information presented described the effectiveness of the intervention with regard to the actions completed through this period. The impact on members was not part of the conclusions about the success of the project. However, with the improvements that were identified to date, it can be inferred that member services have improved. This project is not complete, but does indicate significant potential for success. Sustained improvement could not yet be determined. The format used to document the study findings was greatly improved compared to the original submission. The narrative included a detailed explanation about the process of developing the project and the activities that had occurred.



CONCLUSIONS

QUALITY OF CARE

These PIPs focused on creating quality and adequate services to members in both the clinical and non-clinical approach. A quality approach to assisting members, educating members and facilities, and improving internal processes were evident throughout the documentation provided for both PIPs. By including an active case management process to assist any member who had inpatient mental health treatment, the quality of life and approach to providing services were an obvious component for the clinical PIP. Continued training and process improvement were evident throughout the non-clinical PIP. In both projects the health plan sought to improve the quality of services, or the quality of internal work, which will result in improved member care.

ACCESS TO CARE

Both Performance Improvement Projects submitted by the health plan had a focus that addressed improved access to health care services. The first PIP, regarding improved compliance with obtaining mental health aftercare services, exhibited a clear understanding that access to these services was essential to assisting members in achieving positive mental health outcomes. Efforts were made to ensure that members had access to the type and amount of services required after their inpatient stay. By addressing both inpatient facility barriers, as well as member constraints, the health plan made a concerted effort to improve access for members.

The non-clinical PIP, focused on improving response time in the grievance and appeal process, and also included a focus on access to appropriate healthcare services. By ensuring that the health plan system itself did not create barriers to members getting the health care services needed, access is improved.



TIMELINESS OF CARE

Both projects had a distinct focus on timely and adequate care. In the first PIP regarding follow-up care after inpatient mental health treatment, the health plan sought to ensure that members obtained outpatient treatment within the seven and thirty day time frames required by NCQA standards. In the second PIP regarding improving the grievance and appeal process there was attention to timely processing and decision making to assure that the services needed by the member could be delivered in a timely fashion. The focus of both projects were to ensure that the most timely care be available to members, and to ensure that internal processes or other barriers did not hinder this outcome.

RECOMMENDATIONS

1. The narratives did not include discussion on how the PIP process can be enhanced to improve outcomes based on the barriers and opportunities recognized to create improved outcomes. Conclusions were drawn based on the data that was currently available. However, next steps were not articulated in the information available. The inclusion of this information would ensure that the plan for these ongoing PIPs was clarified.
2. Continue using the expanded written format made available in the additional information submitted and in the information provided after the on-site review to communicate the intentions, planning, and processes utilized in developing and implementing the PIPs.
3. Utilize the Conducting Performance Improvement Project protocol to assist in the process of project development and reporting.

6.2 Validation of Performance Measures

METHODS

This section describes the documents, data, and persons interviewed for the Validation of Performance Measures for Blue-Advantage Plus of Kansas City. Blue-Advantage Plus of Kansas City submitted the requested documents on January 29, 2008. The EQRO reviewed documentation between January 29, 2008 and July 1, 2008. On-site review time was used to conduct follow-up questions and provide feedback and recommendations regarding the performance measure rate calculation.

DOCUMENT REVIEW

The following are the documents reviewed by the EQRO:

- The Baseline Assessment Tool (BAT) submitted by Blue-Advantage Plus of Kansas City
- Ernst & Young's NCQA HEDIS 2007 Compliance Audit Report
- Letters of communication between the EQRO and Blue-Advantage Plus of Kansas City
- Blue-Advantage Plus of Kansas City policies pertaining to HEDIS 2007 rate calculation and reporting
- Blue-Advantage Plus of Kansas City Information Services (IS) policies on disaster recovery
- Blue-Advantage Plus of Kansas City's HEDIS implementation work plan and HEDIS committee agendas for 2007
- Data warehouse validation procedures for the CRMS software
- DB2 data warehouse models of the interim data warehouse

The following are the data files submitted by Blue-Advantage Plus of Kansas City for review by the EQRO:

- ADV Denominator.txt
- ADV Enrollment.txt
- ADV Numerator.txt
- AWC FROM REPOSITORY.txt
- AWC_resubmit for audit_2006.txt
- FUH DENOMINATOR.txt
- FUH ENROLLMENT.txt
- FUH NUMERATOR 7 DAYS.txt
- FUH NUMERATOR 30 DAYS.txt



INTERVIEWS

The EQRO conducted on-site interviews with Michelle Williams, Senior Health Data Analyst and Cheryl Banks, UM Training and Compliance Manager at Blue-Advantage Plus of Kansas City in Kansas City, MO on Wednesday, July 23, 2008. This group was responsible for calculating the HEDIS performance measures. The objective of the visit was to verify the data, methods, and processes behind the calculation of the three HEDIS 2007 performance measures. This included both manual and automatic processes of information collection, storing, analyzing, and reporting.

FINDINGS

Blue-Advantage Plus of Kansas City used the Administrative Method for calculation of the HEDIS 2007 Adolescent Well-Care Visits, Follow-Up After Hospitalization for Mental Illness, and Annual Dental Visits measures. MO HealthNet Managed Care health plan to MO HealthNet Managed Care health plan comparisons of the rates for Adolescent Well-Care Visits, Follow-Up After Hospitalization for Mental Illness, and Annual Dental Visits were conducted using two-tailed z-tests. For comparisons that were statistically significant at the 95% confidence interval (CI), the z-score (z), the upper and lower confidence intervals (CI), and the significance levels ($p < .05$) are reported.

The reported rate for Blue-Advantage Plus of Kansas City for the HEDIS 2007 Adolescent Well-Care Visits measure was 31.54%, significantly lower than the statewide rate for MCHPs (34.81%; $z = -0.33$, 95% CI: 28.89%, 40.74%; $p < .05$). This reported rate is a slight increase over the rate (31.20%) reported by this health plan in the 2004 EQR report.

The reported rate for Blue-Advantage Plus of Kansas City for the HEDIS 2007 Follow-Up After Hospitalization for Mental Illness measure was 58.67% for the 7-day rate, significantly higher than the statewide rate for all MCHPs (35.52%; $z = -$

0.34, 95% CI: 22.96%, 48.08%; $p > .95$); this rate is significantly higher than the 7 – day rate (50.17%) reported by the health plan in the 2006 EQR report. The reported rate was 76.00% for the 30-day rate, also significantly higher than the statewide rate for all MCHPs (60.06%; $z = 1.38$, 95% CI: 47.50%, 72.62%; $p > .95$); this rate was also significantly higher than the 30-day rate (72.76%) reported by the health plan in the 2006 EQR report.

The HEDIS 2007 combined rate for Annual Dental Visits reported by Blue-Advantage Plus of Kansas City was 33.72%, comparable to the statewide rate for MCHPs (32.50%, $z = 0.04$; 95% CI: 29.30%, 35.69%; n.s.). This reported rate is a slight increase over the rate (31.79%) reported by this health plan in the 2005 EQR report.

The following sections summarize the findings of the process for validating each of the performance measures in accordance with the Validating Performance Measures Protocol. The findings from all review activities are presented according to the EQRO validation activity, with the findings for each measure discussed within the activities as appropriate. Please refer to the tables in the main report for activities, ratings, and comments related to the Attachments.

DATA INTEGRATION AND CONTROL

Blue-Advantage Plus of Kansas City used a NCQA-certified vendor application (MedMeasures) for calculation of rates for the HEDIS 2007 measures. The EQRO was given a demonstration of the data flow and integration mechanisms for external databases for these measures, and provided with a layout of the data structure of the internally-developed data warehouse for storing interim data. For the three measures calculated, Blue-Advantage Plus of Kansas City was found to meet all criteria for producing complete and accurate data (see Attachment V: Data Integration and Control Findings). There were no biases or errors found in the manner in which Blue-Advantage Plus of Kansas City transferred data into the repository used for calculating the HEDIS 2007 measures of Adolescent Well-Care Visits, Follow-Up After Hospitalization for Mental Illness, and Annual Dental Visits.

DOCUMENTATION OF DATA AND PROCESSES

Data and processes used for the calculation of measures were adequate (see Attachment VII: Data and Processes Used to Calculate and Report Performance

Measures). Blue-Advantage Plus of Kansas City met all criteria that applied for the three measures validated. Blue-Advantage Plus of Kansas City did utilize statistical testing; BA+ continues to partner with Ernst & Young to best assess how to utilize the information that they obtain from the statistical analysis process.

PROCESSES USED TO PRODUCE DENOMINATORS

Blue-Advantage Plus of Kansas City met all criteria for the processes employed to produce the denominators of the performance measures validated (see Attachment X: Denominator Validation Findings). This involves the selection of eligible members for the services being measured. Denominators in the final data files were consistent with those reported on the DST for the three measures validated. All members were unique and the dates of birth ranges were valid. A total of 4,613 members eligible were reported and 4,613 were validated for the Adolescent Well-Care Visits measure.

There were 225 eligible members reported for the denominator of the Follow-Up After Hospitalization measure, 225 were validated. There were 14,138 eligible members reported and validated for the denominator of the Annual Dental Visit measure.

PROCESSES USED TO PRODUCE NUMERATORS

The measures validated included the appropriate data ranges for the qualifying events (e.g., well-care visits, follow-up visits and dental visits) as specified by the HEDIS 2007 criteria (Attachment XIII: Numerator Validation Findings).

For the HEDIS 2007 Adolescent Well-Care Visit measure, there were a total of 1,455 administrative hits reported by Blue-Advantage Plus of Kansas City and 1,452 validated by the EQRO. The rate validated by the EQRO for Adolescent Visits was 31.48%, an observed bias of 0.07%.

The Follow-Up After Hospitalization for Mental Illness measure is reported in both 7-day and 30-day rates. The number of administrative hits reported for the 7-day rate was 132; 130 of these hits were validated by the EQRO. The reported 7-day rate was 58.67%. The EQRO validated rate was 57.78%, an observed bias of 0.89%. For the 30-day calculation, the reported number of hits was 171 with 170

of these validated by the EQRO. The rate reported for the 30-day calculation was 76.00% and the EQRO validated rate was 75.56%, an observed bias of 0.44%.

The number of hits reported for the combined rate for Annual Dental Visit was 4,768; 4,761 were validated by the EQRO. The reported rate was 33.72% and the validated rate was 33.68%, an observed bias of 0.05%.

No sampling or medical record reviews were conducted or validated for the performance measures validated. CMS Protocol Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings do not apply to the Administrative Method.

SAMPLING PROCEDURES FOR HYBRID METHODS

No medical record reviews were conducted or validated. CMS Protocol Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings do not apply to the Administrative Method.

SUBMISSION OF MEASURES TO THE STATE

Blue-Advantage Plus of Kansas City submitted the DST for all three measures validated to the SPHA (the Missouri Department of Health and Senior Services: DHSS) in accordance with the Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) and the SMA Quality Improvement Strategy.

DETERMINATION OF VALIDATION FINDINGS AND CALCULATION OF BIAS

As noted earlier, some bias was calculated in the HEDIS 2007 Adolescent Well-Care Visits, Follow-up After Hospitalization for Mental Illness, and Annual Dental Visits measures evaluated; all three of these measures were overestimated. However, the bias observed was minimal (less than 1% in each case). The rate validated for each measure fell within the 95% confidence interval reported by the MCHP for that measure.

Table 47 - Estimate of Bias in Reporting of BA+ HEDIS 2007 Measures

Measure	Estimate of Bias	Direction of Estimate
Adolescent Well-Care Visits	0.07%	Overestimate
Follow- Up After Hospitalization (7 days)	0.89%	Overestimate
Follow-Up After Hospitalization (30 days)	0.44%	Overestimate
Annual Dental Visit	0.05%	Overestimate

FINAL AUDIT RATING

The Final Audit Rating for each of the performance measures was based on the findings from all data sources that were summarized in the Final Performance Measure Validation Worksheet for each measure.

Table 48 - Final Audit Rating for BA+ Performance Measures

Measure	Final Audit Rating
Adolescent Well-Care Visits	Substantially Compliant
Follow- Up After Hospitalization (7 days)	Substantially Compliant
Follow-Up After Hospitalization (30 days)	Substantially Compliant
Annual Dental Visit	Substantially Compliant

Note: Fully Compliant = Measure was fully compliant with State specifications; Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate; A significant bias in the rate was defined as a number calculated by the EQRO that fell outside the 95% confidence interval of the rate reported by the health plan. Not Valid = Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported; Not Applicable = No MO HealthNet Managed Care Members qualified for the measure.

CONCLUSIONS

Four rates were validated for the health plan. One of these rates was consistent with; two were significantly higher than; and one was significantly lower than the average for all MO HealthNet Managed Care health plans.

QUALITY OF CARE

Blue-Advantage Plus of Kansas City's calculation of the HEDIS 2007 Follow-Up After Hospitalization for Mental Illness measure was substantially complaint with

specifications. This measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care delivered. The health plan's 7-day and 30-day follow-up reported rates were both significantly higher than the average rate for all MO Health Net Managed Care health plans, as well as being higher than both the National Medicaid Average and the National Commercial Average. The health plan is delivering a level of care higher than that received by both the average MO HealthNet Managed Care member in Missouri and the average Medicaid or Commercial member across the nation. Both of these rates were also significantly higher than the same measure rates reported in last year's EQR report. The plan's focus on this measure is evident in the results they have achieved in these rates.

The EQRO was able to validate this rate within the reported 95% confidence interval and therefore has substantial confidence in the calculated rate.

ACCESS TO CARE

The Annual Dental Visit rate for Blue-Advantage Plus of Kansas City was substantially compliant with specifications; this measure is categorized as an Effectiveness of Care measure. Because only one visit is required for a positive "hit", this measure effectively demonstrates the level of access to care that members are receiving. The rate validated for the health plan was comparable to the overall rate calculated for all MO Health Net Managed Care health plans. Blue-Advantage Plus of Kansas City's members are receiving a level of care consistent with that received by the average MO HealthNet Managed Care member in Missouri. This rate is a slight increase over the rate reported for the 2005 EQR report (the last year this measure was audited by the EQRO).

The EQRO was able to validate this rate within the reported 95% confidence interval and therefore has substantial confidence in the calculated rate.

TIMELINESS OF CARE

The health plan's calculation of the HEDIS 2007 Adolescent Well-Care measure was substantially compliant. This measure is categorized as a Use of Services measure and is designed to measure access to and timeliness of the care defined. The health plan's reported rate for this measure was significantly lower than the average across all MO Health Net Managed Care health plans. Therefore, Blue-Advantage Plus of Kansas City's members are receiving less access to and timeliness of care for this measure than the average MO HealthNet Managed Care members.

The EQRO was able to validate this rate within the reported 95% confidence intervals and thereby has substantial confidence in the calculated rate.

RECOMMENDATIONS

1. Blue-Advantage Plus of Kansas City should utilize hybrid methods where HEDIS specifications recommend using the hybrid approach.
2. Continue work with Ernst & Young to conduct and document statistical comparisons on rates from year to year.
3. The health plan's rate for the Adolescent Well-Care Visits measure was significantly lower than the average rate for all MO HealthNet Managed Care health plans. The EQRO recommends the health plan concentrate efforts to improve this rate.
4. All four of the rates validated by the EQRO showed an increase over the prior year's corresponding rates. The EQRO recommends that the health plan continue to monitor trending in rates from year to year and responding to those trends by increasing efforts for those rates that do not increase or only increase slightly.

6.3 Validation of Encounter Data

FINDINGS

The findings for the encounter data validation are organized according to the encounter data evaluation questions presented in the Technical Methods section for the encounter data validation in the aggregate report. Please refer to the main report for detailed objectives, technical methods and procedures for encounter data validation.

What is the Baseline Level of Completeness, Accuracy, and Reasonableness of the Critical Fields?

For the Medical claim type, there were 84,357 encounter claims paid by the SMA for the period July 1, 2007 through September 30, 2007.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Outpatient Recipient ID field was 100.00% complete, accurate and valid.
3. The Outpatient First Date of Service field was 100.00% complete, accurate and valid.
4. The Outpatient Last Date of Service field was 100.00% complete, accurate and valid.
5. The Outpatient Units of Service field was 100.00% complete, accurate and valid.
6. The Outpatient Procedure Code field 100.00% complete, accurate and valid.
7. The Outpatient Place of Service field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 100.00% complete, accurate and valid.
9. The second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual. Each of these Diagnosis Code fields fell well below the 100% threshold established by the SMA for this validation. The second, third, fourth and fifth Diagnosis Code fields were 49.5%, 22.79%, 12.24%, and 0.00% complete, accurate and valid, respectively. The

remaining fields were blank (incomplete, inaccurate, and invalid).

For the Dental claim type, there were 8,408 encounter claims paid by the SMA for the period July 1, 2007 through September 30, 2007. All of the fields examined were 100.00% complete, accurate and valid.

For the Home Health claim type, there were 231 encounter claims paid by the SMA for the period July 1, 2007 through September 30, 2007. All of the fields examined were 100.00% complete, accurate and valid except the Procedure Code and second through fifth Diagnosis Code fields. The Procedure Code field was 79.22% complete and accurate and valid. The remaining fields (n = 48) were blank. The second, third, and fourth Diagnosis Code fields were 26.84%, 18.61%, 5.63% and 1.73% complete, accurate, and valid, respectively. All remaining fields were blank (incomplete, inaccurate, and invalid).

For the Inpatient claim type, there were 11,582 encounter claims paid by the SMA for the period July 1, 2007 through September 30, 2007.

1. The Inpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Recipient ID field was 100.00% complete, accurate and valid.
3. The Admission Type field was 100.00% complete, accurate and valid.
4. The Admission Date field was 100.00% complete, accurate and valid.
5. The Discharge Date field was 100.00% complete and 99.57% accurate and valid (with 50 entries of "99999999").
6. The Bill Type field was 100.00% complete, accurate and valid.
7. The Patient Status field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 99.99% complete, accurate and valid. The remaining fields (n=77) were blank (incomplete, inaccurate and invalid).
9. The second, third, fourth, and fifth Diagnosis Code fields fell well below the 100% threshold for completeness, accuracy, and validity established by the SMA (86.9%, 69.72%, 57.56%, and 43.77%, respectively). The remaining fields were blank (incomplete, inaccurate, and invalid).
10. The First Date of Service field was 100.00% complete, accurate and valid.
11. The Last Date of Service field was 100.00% complete, accurate and valid.
12. The Revenue Code field was 99.76% complete, accurate and valid. There were four (27) blank fields.
13. The Units of Service field was 100.00% complete, accurate and valid.

For the Outpatient Hospital claim type, there were 36,071 encounter claims paid by the SMA for the period July 1, 2007 through September 30, 2007. All fields examined were 100.00% complete, accurate, and valid except for the Procedure Code and second through fifth Diagnosis Code fields. The Procedure Code fields were 97.69% complete and accurate. The remaining fields were blank (n = 833). The Procedure Code fields were 97.62% valid with incorrect codes (n=26). The second, third, fourth and fifth Diagnosis Code fields fell well below the 100% threshold for completeness, accuracy, and validity established by the SMA (58.23%, 31.28%, 15.80% and 8.69%, respectively). The remaining fields were blank (incomplete, inaccurate, and invalid).

For the Pharmacy claim type, there were 37,963 claims paid by the SMA for the period July 1, 2007 through September 30, 2007. All fields examined were 100.00% complete, accurate and valid.

What Types of Encounter Claim Data are Missing and Why?

Based on the above analysis of the accuracy, completeness, and validity of the data in the SMA encounter claims extract file for Blue-Advantage Plus of Kansas City, an error analysis of the invalid entries was conducted for fields which were lower than the 100.00% threshold specified by the SMA. Dental, Outpatient Medical, and Pharmacy claim type critical fields examined were 100.00% complete, accurate, and valid. For Home Health claims, the Procedure Code field contained some invalid data. The Discharge Date fields for the Inpatient claim type contained some invalid codes.

What is the Level of Volume and Consistency of Services?

When comparing the rate of encounter claim types per 1,000 members, Blue-Advantage Plus of Kansas City demonstrated rates consistent with the average for all MCHPs for the Outpatient Hospital, Pharmacy and Dental claim types; and

a significantly higher rate for Home Health and Inpatient encounter claims. These findings suggest moderate to high access to care for Outpatient Hospital, Pharmacy, Dental, Inpatient and Home Health Care services for Blue-Advantage Plus of Kansas City members.

To examine the degree of match between the SMA encounter claims database and the medical record, 100 encounters from each MCHP were randomly selected from all claim types for the period July 1, 2007 through September 30, 2007 for medical record review.

Of the 178,612 encounter claim types in the SMA extract file for July 1, 2007 through September 30, 2007, 100 encounters were randomly selected. Providers were requested to submit medical records for review. There were 97 medical records (97.0%) submitted for review. Encounters for which no documentation was submitted were unable to be validated. The match rate for procedures was 52.0%, with a fault rate of 48.0%. The match rate for diagnoses was 59.0%, with a fault rate of 41.0%.

What Types of Errors Were Noted?

An error analysis of the errors found on the medical record review for procedure and diagnosis, was conducted. For the diagnosis code in the medical record, the reasons for diagnosis codes not matching the SMA extract file were missing information (n = 32) and incorrect code found (n=9). For the procedure code in the medical record, the reasons for procedure codes in the SMA extract file not being supported by documentation in the medical record were missing information (n = 29), incorrect code (n=8), downcoded (4) and upcoded (7). Examples of missing information included no code; codes listed that were not supported, or codes that did not match the procedure description.

To what extent do the MO HealthNet MCHP paid/unpaid encounter claims match the SMA paid database?

Since Blue-Advantage Plus of Kansas City included internal control numbers that matched those of the SMA, the EQRO conducted the planned analyses comparing MCHP encounter data to the SMA encounter claim extract file. The SMA defined “unpaid claims” as those claims that the MCO denied for payment, unpaid claims do not include claims paid via a capitation plan.

For the Pharmacy Claim type, all encounter data submitted to the EQRO (n = 37,963) was of “paid” status. There were 0 unmatched claims that were in the BA+ encounter file and absent from the SMA data. Thus, 100.00% of the EQRO submitted encounters matched with the SMA encounter records.

For all Outpatient Claim Types (Medical, Dental, and Hospital), 128,836 “paid” encounters 37 “denied” and 68 “unpaid” claims were submitted. All paid encounter claims matched with the SMA encounter claim extract file. The 37 denied claims and 68 unpaid claims were not present in the SMA database (as expected); there was a “hit” rate of 99.99% between BA+ encounter claims and the SMA encounter data.

For the Inpatient Claim Type, BA+ submitted 11,582 encounter claims of “paid” status and 55 “denied” and 1 “unpaid” claims. All paid encounter claims matched with the SMA encounter claim extract file. The denied and unpaid claims were not present in the SMA database.

Why are there unmatched claims between the MCHP and SMA data files?

The unmatched encounters are due to missing ICN numbers which are required to match the encounter to that of the SMA. Therefore, in all claim types, the encounter claims were legitimately missing from the SMA extract data.

What are the Data Quality Issues Associated with the Processing of Encounter Data?

While the MO HealthNet Managed Care health plan did submit the data in the requested format (including most ICN numbers), there are a number of ways to improve the data quality by improving the database system. As the Internal Control Number is only assigned by the State database when a claim is paid, it is difficult to match the MO HealthNet Managed Care health plan data of “unpaid” and “denied” claims to the SMA data. As the Internal Control Number is unique only to the encounter, the ICN may be represented in multiple lines of data. To match the MO HealthNet Managed Care health plan data to the SMA data to specific fields, this requires a unique line number. Therefore each service provided within an encounter would have a separate line of data with a unique line identifier.



CONCLUSIONS

STRENGTHS

1. Encounter data was submitted to the EQRO in the requested format which allowed encounter validation for all claim types.
2. The critical field validation of all six claim types resulted in few fields under the SMA established threshold of 100.00% accuracy, completeness, and validity.
3. The critical fields evaluated for the Dental, Outpatient Medical and Pharmacy claim types were 100.00% complete, accurate, and valid.
4. The rate of Home Health and Inpatient encounter claims was significantly higher than the average for all MO HealthNet Managed Care health plans.

AREAS FOR IMPROVEMENT

1. For the Home Health claim type, the Procedure Code fields contained invalid entries.
2. For the Inpatient claim type, there were invalid dates in the Discharge Date fields; also there were blank Revenue Code fields.
3. The Outpatient Procedure Code field in the Hospital claim type contained invalid fields.
4. The rate of Inpatient encounter claims was significantly lower than the average for all MO HealthNet Managed Care health plans.

RECOMMENDATIONS

1. Examine and revise as needed internal system edits for invalid procedure codes in the UB-92 file layout for the Outpatient Procedure Code and Discharge Date fields
2. Run validity checks after the programming of new edits.

6.4 MO HealthNet MCHP Compliance with Managed Care Regulations

METHODS

Prior to the site visit, documentation was received and reviewed regarding the MO HealthNet Managed Care Health Plan's compliance with the State contract. The External Quality Review Organization (EQRO) reviewed contract requirements with the staff of the MO HealthNet Division (MHD). This ensures that documentation is developed and practices occur within the scope of the contract and in a manner that meets or exceeds federal regulations.

A detailed protocol (BHC MO HealthNet Managed Care Health Plan Compliance Review Scoring Form) was utilized to ensure that all the elements of the federal regulations were addressed in the review process. Document reviews occurred on-site to validate that practices and procedures were in place to guide organizational performance.

On-site review time was used to conduct interviews with Member Services' Staff and Supervisors, and separately with Case Management Staff and Supervisors. This approach was utilized to validate that practices that occur when serving members. These interactions and responses were compared to policy requirements to ensure that both are within the scope of the contract and are conducted in a manner that meets or exceeds federal regulations.

A detailed interview tool, individualized for Member Services' Staff and for Case Management staff, was utilized to ensure that all pertinent elements of the federal regulations were addressed in the interview process. Additionally, an interview tool was constructed for administrative staff to validate and clarify these practices and to follow-up on questions raised from the interviews.

DOCUMENT REVIEW

The MO HealthNet Division supplied:

- State of Missouri Contract Compliance Tool (including MHD responses and comments)

The following documents were requested for on-site review:

- Member Handbook
- Provider Handbook
- Credentialing Policies and Audit Reports
- Policy Tracking Log
- Grievance Logs for Member and Providers
- 2007 Annual Appraisal of the Quality Improvement Program

Additional documentation made available by Blue-Advantage Plus included:

- 2007 Marketing Plan and Educational Material Development Policy
- Blue-Advantage Plus of Kansas City Organizational Chart
- BA+ Brochures – English/Spanish versions
- 2007 Well Aware Newsletters (Member)
- 2007 Blue Speak Newsletters (Provider)
- 2007 BA+ Policy Spreadsheet
- BA+ Report Card - 2007

INTERVIEWS

Interviews were conducted with the following groups:

Plan Administration

- Judy Brennan – Director, State Programs, Plan Administrator
- Dr. Loretta Britton – VP, Medical Director
- Sandy Wederquist, RN – Director, Medical Management
- Shelly Bowen – AVP, Quality Management

- Tylisa Wyatt – Compliance Analyst
- Wes Wadman – MHIP Coordinator
- Wayne Burge – Vice President, Provider Contracting and Reimbursement
- Dennis Radio – Director, Professional Services
- Randy Meyer – Director, Hospital Services
- Thutam Trieu – Director, Member Services

Member Services Staff

- Thatum Trieu – Director, Member Services
- Trish Mahurin, Supervisor, Member Services
- Lanna Golliglee, Tech Specialist
- Annie Magana, Claims
- Eric Crumble, Customer Services
- Carmen Maddox, Membership
- Tylisa Wyatt, CGA

Case Management Staff

- Dr. Loretta Britton – Medical Director
- Sandy Wederquist –Director, Medical Management
- Rhonda Janky – Case Manager
- Cindy Hochart – Population Management

FINDINGS

ENROLLEE RIGHTS AND PROTECTIONS

Blue-Advantage Plus continued to exhibit commitment and enthusiasm toward ensuring that member rights and protections are in place. There was a significant change in the atmosphere, which seemed to empower the administrator of the program and invite front line staff to be involved in the operations of the program. Members Services staff were proud of their record in

contacting new members quickly after the health plan learned of enrollment. A variety of continued contacts are made if initial attempts failed. Written information was provided in English or Spanish. If additional interpretive services were required, this was arranged for the member.

Blue-Advantage Plus made changes in a number of processes to make service delivery easier for members. In January 2005 the health plan stopped requiring a primary care physician (PCP) referral for specialist care. This process continues and staff report that this has assisted members in obtaining more timely health care. Communication is requested between physicians, with the goal of contact occurring between specialists and PCPs, within one day. If the situation is an emergency the Medical Director, Dr. Loretta Britton, is involved. Dr. Britton also becomes involved if a timely appointment cannot be made. Quality improvement staff monitors appointment access regularly to insure that this important component meets all requirements.

A complex case management program has been added to the already available catastrophic case management program. Nurses will now get regular reports from the emergency rooms and from hospitals. Nurses review all emergency room visits within one week. If a visit is not urgent, contact is made with the member to educate them on obtaining PCP care regularly and to provide assistance in overcoming barriers to the member's utilization of PCP services. These case managers also review claims histories to assess where healthcare has been received. Outreach to PCPs requesting their contact with members to engage them in utilizing their medical home is also made. BA+ is working with American Academy of Family Practice (AAFP) to support members in maintaining a medical home.

BA+ operates the Healthy Companion program, which is an umbrella for healthy living initiative that includes prevention, disease management, and a relationship with a nurse case manager. This information and process is available to all BA+ members. The case manager schedules calls at the member's convenience. Outreach additionally occurs when a problem arises, such as a negative laboratory report. The program includes an interface with local public health departments and a monitoring program for diabetics and members with hypertension. The system is also shared with New Directions Behavioral Health,

the health plan's behavioral health subcontractor. Feedback is provided regarding the medical perspective on consultations for members with multiple problems. This process ensures timely access to follow-up care when referrals are made.

BA+ now has access to more information through their data warehouse regarding members with special health care needs. The BA+ member list is run through the data warehouse looking for a diagnosis if something occurs that is not routine. When a problem is identified, the member is referred to case management for follow-up contacts and services. This report is run for lead case management and cases relating to the Jackson County Consent Decree. The health plan utilizes the State Health Needs Assessment, which is helpful in identifying members who need behavioral health services, and those who are pregnant.

The health plan uses a predictive modeling tool, Care Advance, to search through data and detect members who are at risk of needing care management services. Data used by the case managers included claims, pharmacy utilization, laboratory results, and self-reported information. Follow-up contact with members occurs with all at-risk members detected, particularly those with diabetes, heart disease, and COPD. The members receive prompts to: make medical appointments; identify the need for chronic disease treatment; and to create comparisons to best practice guidelines. The case managers perform assessments to submit to involved providers. Tutorials for chronic diseases, such as asthma and diabetes are available and providers will be able to use this information, as well as patient tracking information.

Member Services staff report that they make welcome calls to all new members to review benefits and to discuss the member's medical needs. The assigned PCP is discussed with the member to ensure that this is the provider of choice. Changes are made if necessary. The Member Services staff also contacts the PCP to ensure that the member is in their panel and that there will be no problem when an appointment is sought. The Member Services staff also informs members of the right to transportation services, and ensures that they know how to request this service should it be necessary. Member Services staff discuss cultural issues, if appropriate, ensure that the member is comfortable with the

PCP, and ask about language or other cultural considerations.

Case managers report that they have over fifty years of combined experience. They were able to discuss all potential referral sources. Upon receipt of a new referral the case managers review member claims, MOSAIC, prior authorizations, and any available clinical notes. The member is contacted and engaged in the assessment process. Case Managers explain their case management role and tailor their treatment plan to best meet member's needs. Each case is assessed for low to high acuity, which becomes a guide for the frequency of follow-up. Case Managers ensure that the member has a medical home, if aware of available health care services, and other social supports that may be beneficial such as WIC or Food Stamps.

Case Managers provided concrete examples of how they engage a variety of services to meet a member's needs. One example was that of a two-year old with hemophilia. The mother was not a member and spoke Spanish. The case manager contacted her using the ATT interpreter, and learned that there was a problem of pests in the living arrangement. The mother was experiencing depression related to her son's condition. The Case Manager made a referral for the mother to New Directions Behavioral Health, and also to Swope Medical Center. A home infusion provider was engaged to see the son on site, and arrangements were coordinated by Jackson County Social Services for the landlord to perform frequent exterminations of the living quarters.

The rating for Enrollee Rights and Protections (100.0%) reflects Blue-Advantages Plus's ability to have all policy and procedures submitted and approved by the SMA in a timely manner for the third consecutive year. The health plan provided evidence of their practice throughout the on-site review process. It appears that the health plan is in compliance with all MO HealthNet Managed Care contract regulations and federal requirements.

Table 49 – Subpart C: Enrollee Rights and Protections Yearly Comparison (BA+)

Federal Regulation	BA+		
	2005	2006	2007
438.100(a) Enrollee Rights: General Rule	2	2	2
438.10(b) Enrollee Rights: Information Requirements	2	2	2
438.10(c)(3) Alternative Language: Prevalent Language	2	2	2
438.10(c)(4,5) Language and Format: Interpreter Services	2	2	2
438.10(d)(1)(i) Information Requirements: Format/Easily Understood	2	2	2
438.10(d)(1)(ii) and (2) Information Requirements: Format Visually Impaired, and Limited Reading Proficiency	2	2	2
438.10(f) Information for All Enrollees: Free Choice, etc.	2	2	2
438.10 (g) Information to Enrollees: Specifics/Physician Incentive Plans	2	2	2
438.10(i) Special Rules: Liability for Payment/Cost Sharing	2	2	2
438.100(b)(2)(iii) Enrollee Rights: Provider-Enrollee Communications	2	2	2
438.100(b)(2)(iv,v) Rights to Refuse Services/Advance Directives	2	2	2
438.100(b)(3) Right to Services	2	2	2
438.100(d) Compliance with Other Federal/State Laws	2	2	2
Number Met	13	13	13
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	100.0%

Note: 0 = Not Met; 1= Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols.

BEHAVIORAL HEALTH

Interviews occurred at the time of the on-site review with Blue-Advantage Plus and administrators from their Behavioral Health Organization (BHO), New Directions Behavioral Health (NDBH). They reported on new programs that occurred during 2007.

NDBH was asked about accuracy and timelines of claims issues, which was raised as an issue in their annual report. The BHO explained that they had taken steps to improve in this area. They now meet with provider office managers

quarterly and all transactions are handled electronically. They have a broad network of providers, but this situation has improved and claims are being submitted and paid in a timely manner after corrective action was implemented.

New Directions Behavioral Health continued to jointly operate the Parents and Children Together (PACT) program with the Gillis Center. The PACT program has been in place for nine years. This program provides intensive interventions for members and their families, with follow-up services within the community. The Gillis Center now employs 26 trained therapists for this program. The BHO estimates that between twenty and thirty percent of members receiving sub-acute level care are referred for PACT services. PACT provides direct services and assists the family with community resources. For example, the program connected members and their families with their Community Mental Health Clinic (CMHC) for wrap around services or other beneficial interventions. Referrals are also made to Marillac Center for coordination with school programs and residential placement, if this becomes necessary. This service usually lasts only slightly longer than average inpatient treatment stays, and avoids court-involved out-of-home placement. These services, exceptional to the requirements of the MO HealthNet Managed Care contract, assist members leaving in-patient care, and in some cases prevented in-patient care. Providing this type of support mechanism allowed the health plan to increase ambulatory follow-up for members leaving in-patient services at the seven and thirty-day time frames.

NDBH has continued to develop their collaborative efforts with PCPs. They ensure that the PCP is notified immediately if a member enters inpatient treatment. Anytime there is a drug overdose reported, the BHO ensures that the PCP receives notification.

The BHO has developed clinical guidelines that are posted on the health plan's website. These are reviewed annually by the BA+ Quality Improvement Team. They have also developed ADHD guidelines for providers and members. These are posted on the health plan's website. They have been unable to produce this information at the sixth grade reading level (as required by State statute), so are unable to distribute to all MO HealthNet Managed Care members.

However, these are mailed to members any time they are requested.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT**Access Standards**

Blue-Advantage Plus of Kansas City continued to have an extensive provider network available. The health plan reported that having regular access to orthopedic surgeons, neurologists and urologists was difficult. Blue-Advantage Plus has set up out-of-network agreements with orthopedic surgeons at Truman Medical Center for hand surgery. Three urologists from the Kansas City area, and one from the Warrensburg area have been added to their network in 2006 and continue to provide services to BA+ members in 2007. Some specialists remain dissatisfied with the MO HealthNet Managed Care reimbursement rates. Blue-Advantage Plus does utilize specialists from their commercial network and reimburses them at twenty percent over the Medicaid fee schedule. Customer Service staff continued active recruitment efforts for specialty medical providers. Urgent care centers associated with OSCO Drugs and Walgreen's are now available to BA+ members as well.

The health plan reported that their relationship with providers continued to improve during 2007. Blue-Advantage Plus continues to operate their providers' advisory committee that they utilize for review of internal policies and activities. Physician complaints and member satisfaction surveys were used to trigger corrective actions and educational opportunities with providers. Provider Relations representatives contact any office that is found to be out of compliance with the after-hours access requirements. All member complaints regarding lack of after-hours access are forwarded to provider relations. The appropriate representative contacts the provider office and provides educational information to staff. The Blue-Advantage Plus requirements are reviewed and coaching is provided about what type of directions for members must be in place. Follow-up continues until all corrective action is in place. The five representatives visit their assigned providers quarterly.

Blue-Advantage Plus also reported initiating corrective action with their

transportation subcontractor, MTM. A corrective action plan was developed to reduce call abandonment and to improve call response time. These efforts resulted in improvement in services. The health plan has quarterly meetings with MTM to review call information and to provide follow-up on complaints or problems experienced.

Member Services staff discuss issues with members, such as providers terminated from the BA+ Panel. The member is advised of these changes by letter, but they often call Member Services for clarification. Member Services staff assist in identifying a new provider or PCP. They often discuss access to after-hours services. They refer members to urgent care centers and the Nurse Line. Follow-up occurs with the provider and a referral is made to the Provider Relations section.

Case Managers are involved with ensure that members have access to quality and timely health care on a daily basis. They assist members in locating specialists, in obtain normal health care services, as well as extraordinary services when they are required. Through the Care Coordination programs and the Healthy Companion Program, members with specific diseases obtain regular and adequate health care.

Ratings regarding Access Standards regulations (100%) reflect that Blue-Advantage Plus submitted all required policy and procedures to the SMA for their approval for the third consecutive year. During the on-site review all practices observed indicated that the health plan made a concerted effort to ensure that they were compliant with the MO HealthNet Managed Care contract requirements and all federal regulations.

Table 50 – Subpart D: Quality Assessment and Performance Improvement: Access Standards Yearly Comparison (BA+)

Federal Regulation	BA+		
	2005	2006	2007
438.206(b)(1)(i-v) Availability of Services: Provider Network	2	2	2
438.206 (b) (2) Access to Well Woman Care: Direct Access	2	2	2
438.206(b)(3) Second Opinions	2	2	2
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	2	2	2
438.206(b)(5) Out of Network Services: Cost Sharing	2	2	2
438.206(c)(1)(i-vi) Timely Access	2	2	2
438.206(c)(2) Provider Services: Cultural Competency	2	2	2
438.208(b) Care Coordination: Primary Care	2	2	2
438.208(c)(1) Care Coordination: Identification	2	2	2
438.208(c)(2) Care Coordination: Assessment	2	2	2
438.208(c)(3) Care Coordination: Treatment Plans	2	2	2
438.208(c)(4) Care Coordination: Direct Access to Specialists	2	2	2
438.210(b) Authorization of Services	2	2	2
438.210(c) Notice of Adverse Action	2	2	2
438.210(d) Timeframes for Decisions, Expedited Authorizations	2	2	2
438.210(e) Compensation of Utilization Management Activities	2	2	2
438.114 Emergency and Post-Stabilization Services	2	2	2
Number Met	17	17	17
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	100.0%

Note: 0 = Not Met; 1= Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols.

Structures and Operation Standards

Blue-Advantage Plus provided regular oversight to all subcontractors. The health plan meets with New Directions Behavioral Health, and MTM at regular Delegated Oversight Quality Meetings. They continue to meet with Doral Dental on a monthly basis to monitor a correction action plan that is in place.

Blue-Advantage Plus implemented CareGuide QI software. This tool allowed for more efficient documentation of the Milliman Criteria and has allowed nursing

staff to make more informed medical management decisions. Using this tool in collaboration with provider discussions allowed for the most appropriate authorization of inpatient services. The Milliman Criteria provided a guide for medical practice. However, the health plan also used specific practice guidelines from the American College of Obstetricians and Gynecologists (ACOG) and the Academy of Pediatrics. Practice guidelines are distributed by the Provider Relations Representatives. This group also assesses if the practice guidelines are in place and utilized. All providers were encouraged to recognize best practices and follow nationally accepted guidelines.

The credentialing policies and procedures were reviewed and found to be compliant with SMA contract requirements and federal regulations. The policies and procedures follow NCQA and URAC standards. A list of all providers and their credentialing dates is maintained by the health plan to assure that re-credentialing is completed as required.

The Blue-Advantage Plus Customer Service operation has continued to improve. Customer representatives offer members options for care, especially after hours. A scripting matrix was added so representatives can look up procedures pertaining to the member's inquiry, and provide adequate information. The system incorporates prompts for staff to ensure that language and level of explanation meet member needs. Talking points are highlighted in all links. Cross training of this system occurs with Member and Customer Services staff so they can provide back up.

Member Services and Case Managers are not directly involved in these issues. They are aware of the steps to take if a member requests disenrollment or if there is a question about approving or denying benefits.

Ratings for compliance with Structure and Operation Standards regulations (100%) reflect that Blue-Advantage plus has completed all policy and

procedural requirements of the SMA for the third consecutive year. All practice observed during the on-site review supported that the health plan has made every effort to be compliant with both the MO HealthNet Managed Care contract requirements and federal regulations.

Table 51 – Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison (BA+)

Federal Regulation	BA+		
	2005	2006	2007
438.214(a,b) Provider Selection: Credentialing/Recredentialing	2	2	2
438.214(c) and 438.12 Provider Selection: Nondiscrimination	2	2	2
438.214(d) Provider Selection: Excluded Providers	2	2	2
438.214(e) Provider Selection: State Requirements	2	2	2
438.226 and 438.56(b)(1-3) Disenrollment: Requirements and limitations	2	2	2
438.56(c) Disenrollment Requested by the Enrollee	2	2	2
438.56(d) Disenrollment: Procedures	2	2	2
438.56(e) Disenrollment: Timeframes	2	2	2
438.228 Grievance System	2	2	2
438.230(a,b) Subcontractual Relationships and Delegation	2	2	2
Number Met	10	10	10
Number Partially Met	0	0	10
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	100.0%

Note: 0 = Not Met; 1= Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols.

Measurement and Improvement

Blue-Advantage Plus took extra effort to deal with the issue of Fraud and Abuse in 2006 and these efforts continued in 2007. They moved their Special Investigation Unit into Audit Services to assist in facilitating the process of identifying and rectifying fraud and abuse. When fraud and abuse is suspected, the health plan does not renew provider contracts at their next renewal date. Other actions involve education of providers regarding identified problem areas. The professional investigation unit was originally established in 2004, was active throughout 2007, and continues to assist when a suspected problem arises.

The health plan reports that their network includes more than 1600 physicians. They are experiencing fewer complaints each year. Blue-Advantage Plus staff

believe this is due to the longevity of the relationships with most of these providers. The health plan employs a Physicians Advisory Committee and provides information and training prior to making policy and procedural changes. This group assists in communicating necessary changes within the provider community. Physician profiling occurs and incentives are in place through the health plan's Quality Program. Quarterly audits are completed and communicated to all providers.

Blue-Advantage Plus was involved in the community-based Kansas City Quality Improvement Consortium. The group developed clinical practice guidelines for diabetes and asthma. The group has also completed obesity guidelines. The health plan continues to encourage all providers to use practice guidelines accepted by national organizations, as well as those based on local standards. The health plan used the Providers Office Guide and health plan newsletters to disseminate information about practice guidelines to the provider community.

Blue-Advantage Plus submitted all required information to complete the Validation of Performance Measures, as requested. They continue to operate a health information system within the guidelines of that protocol. All encounter data requested was provided in the correct format. The details regarding these areas of validation can be reviewed within specific sections of this report.

If practice guidelines or other written information is requested by a member it is referred to Tylisa Wyatt, Compliance Analyst. She then sends out required information. Staff was not aware of members specifically asking for specific practice guidelines in the past year.

Ratings for the Measurement and Improvement sections were found to be (100%) for the third consecutive year, which reflects that all required policy and practice meets the requirements of the MO HealthNet Managed Care contract and the federal regulations.



Table 52 – Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement Yearly Comparison (BA+)

Federal Regulation	BA+		
	2005	2006	2007
438.236(b)(1-4) Practice Guidelines: Adoption	2	2	2
438.236(c) Practice Guidelines: Dissemination	2	2	2
438.236(d) Practice Guidelines: Application	2	2	2
438.240(a)(1) QAPI: General Rules	2	2	2
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCO Quality Improvement and PIPs	2	2	2
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	2	2	2
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	2	2	2
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	2	2	2
438.240(e) QAPI: Program Review by State	NA	NA	NA
438.242(a) Health Information Systems	2	2	2
438.242(b)(1,2) Health Information Systems: Basic Elements	2	2	2
438.242(b)(3) Health Information Systems: Basic Elements	2	2	2
Number Met	11	11	11
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	100.0%

Note: Regulation 438.240(e) refers to program review by the state. The regulation requires the state to review, at least annually, the impact and effectiveness of each MCHP's quality assessment and performance improvement program. The regulation refers to the state QA & I program review process and is not applicable to External Quality Review of the MC+ Managed Care Program. This percent is calculated for the regulations that are applicable to the MC+ Managed Care Program. 0 = Not Met; 1 = Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols.

Grievance Systems

The Grievance and Appeals system was moved under the umbrella of Blue-Advantage Plus to facilitate improved response time to member and provider complaints, grievances and appeals. The health plan reports that this change has had positive results to date.

The health plan utilizes a Medical Member Appeal Panel, which is staffed by the

Medical Director, two policy holders, and a Blue-Advantage Plus representative, who serves as a neutral team member. Decisions are made by the panel. If an appeal is not overturned by the panel, the appeal is sent out for review by an independent review organization.

Grievances involving subcontractors are sent to the Quality of Care Committee. When the issue involves a provider, the health plan's provider relations staff investigate and then assist in addressing the problem.

Both Case Managers and Member Services staff are aware of all the requirements of the Grievance and Appeals system. They assist members in making referrals and negotiating the system, as necessary.

Rating for compliance with Grievance System regulations (100%) remained complete as occurred for four consecutive program years. The health plan takes pride in their Grievance and Appeal policy and procedures. All practice witnessed at the time of the on-site review, was in compliance.

Table 53 – Subpart F: Grievance Systems Yearly Comparison (BA+)

Federal Regulation	BA+		
	2005	2006	2007
438.402(a) Grievance and Appeals: General Requirements	2	2	2
438.402(b)(1) Grievance System: Filing Requirements - Authority	2	2	2
438.402(b)(2) Grievance System: Filing Requirements - Timing	2	2	2
438.402(b)(3) Grievance System: Filing Requirements - Procedures	2	2	2
438.404(a) Grievance System: Notice of Action - Language and Format	2	2	2
438.404(b) Notice of Action: Content	2	2	2
438.404(c) Notice of Action: Timing	2	2	2
438.406(a) Handling of Grievances and Appeals: General Requirements	2	2	2
438.406(b) Handling of Grievance and Appeals: Special Requirements for Appeals	2	2	2
438.408(a) Resolution and Notification: Basic Rule	2	2	2
438.408(b,c) Resolution and Notification: Grievances and Appeals - Timeframes and Extensions	2	2	2
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	2	2	2
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	2	2	2
438.410 Expedited Resolution of Appeals	2	2	2
438.414 Information about the Grievance System to Providers and Subcontractors	2	2	2
438.416 Recordkeeping and Reporting Requirements	2	2	2
438.420 Continuation of Benefits while Appeal/Fair Hearing Pends	2	2	2
438.424 Effectuation of Reversed Appeal Resolutions	2	2	2
Number Met	18	18	18
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	100.0%

Note: 0 = Not Met; 1= Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols

CONCLUSIONS

Blue-Advantage Plus has excelled in meeting all policy, procedure, and practice areas of compliance with both the MO HealthNet Managed Care contract requirements, and the federal regulations for the third consecutive year. The health plan strengthened their programs, and engaged in a number of initiatives that served to improve the quality, access and timeliness of service to their members. Blue-Advantage Plus pointed to their member loyalty as proof of their focus on meeting member needs. The health plan continues to operate, expand, and create initiatives, several in conjunction with the Behavioral Health Organization, that go beyond the strict requirements of their contract. These initiatives focus on prevention in an effort to avoid more intrusive treatment for members. Blue-Advantage Plus dedicates resources enabling staff to be responsive and supportive to members by ensuring that their healthcare needs are met in an effective and efficient manner.

QUALITY OF CARE

The quality of healthcare services produced through Blue-Advantage Plus remains high as a result of their commitment to continuing quality improvement. The health plan utilizes advisory groups from the community and physicians to ensure that they have a sound perspective on methods that work and where improvements are necessary. The health plan subcontracts with New Directions Behavioral Health. Quality services are produced and are reflected in their exceptional initiatives, such as coordination of case management activities, the PACT, and Personal Transition Services (PTS) programs.

ACCESS TO CARE

Blue-Advantage Plus exhibits their commitment to access to care through their enhanced service initiatives. They have developed new initiatives that improve member services and utilize health plan resources, such as Care Advance, a

project that uses health plan data to inform them about member issues. They participate in community activities to ensure that members have the best information on primary care providers and specialists.

TIMELINESS OF CARE

Blue-Advantage Plus demonstrates their commitment to ensure the timeliness of healthcare by the improvement projects they undertake and new initiatives started each year. Examples of these programs include the BA+ Complaint Process, “Race for Resolution,” which is a well constructed and important initiative that improved the health plan’s responsiveness and timelines to both member grievances and appeals, and provider complaints, grievances, and appeals.

RECOMMENDATIONS

1. Continue development of projects utilizing available resources and data to justify and assist in understanding member service needs.
2. Continue development and use of products, such as CareAdvance, in predictive modeling and supporting empowerment of members to seek appropriate health interventions.
3. Continue efforts to improve behavioral health services, such as monitoring inpatient facilities, completing proactive discharge planning, and aftercare services.

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7.0 Children's Mercy Family Health Partners

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7.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

Children's Mercy Family Health Partners supplied the following documentation for review:

- Improving Well Child Visits in the First 15 Months of Life
- Improving Non-Emergency Transportation Services

The health plan supplied data at the time of the on-site review including narrative information and data analysis. Some additional information was supplied after the on-site review as a final submission of statistical analysis.

INTERVIEWS

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on July 22, 2008, during the on-site review at the Kansas City, Missouri offices, and included the following:

Ma'ata Touslee – Director, Health Services
Jenny Hainey – Manager, Quality Management
KaMara Sams – Project Manager, Health Improvement
Greg Hanley – Manager, Health Improvement/Disease Management

Interviewees shared information on the validation methods, study design, and findings. Technical assistance regarding study design and presentation of findings was provided by the EQRO. The following questions were addressed:

- Was the population for the study expanded?
- How were the accuracy, consistency, and validity assured?
- What findings were relevant to the MO HealthNet managed care population?
- How was improvement analyzed?

- What are the conclusions about the effectiveness of the interventions analyzed?

FINDINGS

The first PIP evaluated was "Improving Well-Child Visits in the First 15 Months of Life." The study topic was well developed based on the health plan's HEDIS rates as compared to the HEDIS Medicaid mean and the Missouri Medicaid mean. The health plan identified a decrease in their rate for the period from 2000 to 2005 and chose this topic to improve this measure as an important preventive effort in child health. The study focused on correcting deficiencies in care of any member who should be receiving the well-child visits. No members were excluded who fell within the spectrum of the query date identified. The topic choice and rationale were well supported by a review of local issues and comparisons to State and national trends. A thorough literature review was conducted and the outcomes included in the documentation submitted.

The hypothesis, and basis of the study, is that parents who receive information and reminders are more likely to:

- Schedule a well child visit
- Receive annual EPSDT exams
- Receive recommended immunizations per schedule

These families are less likely to:

- Have sick child visits
- Miss recommended immunizations

The premise of the study and the corresponding study question are simple and focused.

The study question is: "Do reminder letters to the parents of children ages 0-15 months, who need well-child exams result in increased rate of children with six or more visits by their 15 month birth date?" The approach utilized allowed the health plan to analyze if this single intervention is effective, prior to addressing broader causes or barriers to members receiving these services. It is possible for

this study to evolve and become more complex in time.

The study indicator was the rate of well-child visits in the first 15 months of life for children in the study group. The study group included children identified in a query based on a specific date for the ages of the children involved, and who had received 0 to six well child visits. The indicator measured would indicate a change in health status and is focused on the issue of improving preventive care. The issues that can be tracked are delineated in the hypotheses. The query group was defined as children within a specific birth range. These members were tracked throughout the intervention. It is noted that HEDIS specifications were followed throughout the study. Additionally, the health plan analyzed factors that could influence improvement from the baseline through the second study period to ensure that all factors are reflected in the analysis of a positive change.

The study planned to query claims data to create baseline statistics. Additional queries occurred at quarterly intervals to obtain data the effectiveness of the intervention. The narrative clearly defined the sources of data and a systematic approach to obtaining data that provided confidence that it would be valid and reliable. A prospective data analysis plan was documented. It was based on the measurement of increased well-child visits post intervention. The date to be collected was presented clearly and understandably through the entire discussion of the study design and the prospective data analysis plan. It is noted that the study design was developed with the health plan's Health Improvement Committee. The development of the study design included input from practitioners and physicians. This approach to study design provides evidence of the health plan's commitment to sincere improvement of their processes to enhance service delivery to its members.

Proposed interventions, barrier analysis, data analysis and the quality

improvement processes were described and explained in a manner that enhanced project analysis. Reasonable interventions were developed. These included direct member contact through letters including the well child schedule. The approach provided education to each family regarding the importance of scheduling the required well-child examinations.

The documentation received included the preliminary analysis of the project. This was an in-depth analysis on the information available to date. The information provided did indicate an overall improvement in members obtaining well-child visits. The graphs and charts provided were clear and understandable. They did correlate to the narrative explanation. The information provided compared the baseline and re-measurement data. The analysis provided did explain the data and the results. The enhanced information submitted after the on-site review indicates a complete set of testing for statistical significance. These tests determined that there was a positive impact as the result of implemented interventions. The average number of well-child visits increased by 2.5, which was a significant increase. The change, identified by the increase in well-child visits, was significant at the 95% confidence level.

The documentation did include a plan for improvement after the completion of the initial intervention. The initial evaluation determined that the intervention did have positive impact on member behavior. The plan for improvement indicates that new interventions are planned to create additional positive results for members receiving well-child visits in the first 15 months of life. The study continued to be developed during the past cycle and the information obtained has allowed the health plan to assess the effectiveness of the intervention strategies and to obtain significant and sustained improvement. As the result of the PIP, the health plan will continue to send reminder letters to all members in the first 15 months of life on an annual basis.

The second PIP evaluated was "Improving non-emergent transportation services to members." This was submitted as a non-clinical Performance Improvement Project. The study topic was developed with the choice justified in the narrative. This is a difficult issue to address and the information presented indicates a thorough investigation of the need for improvement. This information was not based on any external information or literature review. The study is based on sound reasoning and a clearly identified local need. This project is presented as a serious attempt to solve a performance problem. It is also based on a desire to improve the ability of members to access health services.

The project was clearly focused on correcting deficiencies in the members' ability to access services. It was based on the hypotheses that developing an operational action plan and conducting frequent oversight visits with the transportation vendor:

- Will increase utilization of transportation services per thousand;
- Will decrease transportation related grievances per thousand; and
- Will increase the percentage of unique members served per thousand.

The project was open to any member requesting transportation services. The study question is: "Will developing an operational action plan and conducting more frequent oversight visits with transportation vendors:

- a. Increase utilization of transportation service per thousand members by 20%;
- b. Decrease transportation related grievances per thousand members by 20%; and
- c. Increase the percentage of unique members served per thousand members by 20%?"

The question is clear and delivered in an informative manner that indicates a plan for the entire project. The topic and expected achievements are clearly identifiable. The key indicators presented are the ratio of utilization of transportation services, the rate of member grievances, and the percentage of unique members served. These indicators are straightforward, simple, and understandable. The indicators are applicable to the study topic. These indicators measure the functional status of a service provided to members and provide the health plan with a measure to indicate the success of proposed interventions. The study population includes any health plan member requesting transportation services.

The information provided a baseline determined by a sound study design for data collection. Documentation included a prospective data analysis and collection plan for the study that is appropriately detailed. The narrative included information on the use of the statistician available to the health plan. Data analysis will be performed quarterly and will include control charting and a comparative analysis of pre and post-intervention effectiveness, as well as an assessment of study variables. Data sources were defined and specific. Analysis does include a summary provided to the Community Advisory Council for member advocate and member input.

The planned intervention was the implementation of an operational action plan and frequent oversight meetings with the transportation vendor. The intervention was described in detail and included post-intervention planning.

Data analysis was completed for the baseline year 2006 and for 2007. The information was preliminary and included a change in vendors. The original vendor was not showing improvement and was replaced. The change in vendors triggered more intense interventions, such as increased oversight meetings. The health plan tracked unique and unduplicated member numbers and grievance numbers. At the end of 2007 there was a decrease in transportation grievances. The health plan believes in the change in vendors, improved network, and increased oversight resulted in this positive impact, but the improvement was not large enough to be statistically significant. The health plan will continue with these efforts in the future in the hope to have a significant impact.

The health plan looked at a real and difficult issue and created a concrete action plan to impact the problems with non-emergent transportation services. The project utilized community advisory and internal committees to define the problem and evaluate success. The project has the continued potential to have significant positive impact on member services and organization functioning.

CONCLUSIONS

QUALITY OF CARE

Quality services are provided in the most appropriate environment, and in a preventive manner, whenever possible. These two projects embodied these values and sought to enhance the services available to the MO HealthNet managed care members. Quality healthcare is evident in the types of

interventions used in these projects. The strong reliance on case management and a personal approach to educating and assisting members is evidence of the commitment to quality services to members.

ACCESS TO CARE

The focus of both of the Performance Improvement Projects developed by the health plan indicated a strong commitment to improving access to the best healthcare in the most appropriate medical setting. In the first PIP the health plan provided education about the importance of accessing preventive healthcare services. In the second project reviewed the health plan attempted to provide enhanced services to members enabling them to obtain non-emergent transportation services efficiently. Both projects enhanced members' ability to access health care services.

TIMELINESS OF CARE

The PIP regarding Well-Child Visits in the First 15 Months of Life concentrated on timely preventive care for children in this age range. The educational approach taken by this PIP empowers families to make sound decisions that can lead to continued efforts to obtain timely preventive healthcare services on an ongoing basis. The PIP that focused on improving non-emergency transportation services directly impacted members' ability to access timely health care. The project sought to ensure that members had requested and appropriate transportation services available when they needed it to ensure that health care appointments were kept and needed health care services were received.

RECOMMENDATIONS

1. Continue the work the health plan is doing with the statistician to perfect PIP methodology and data analysis.

2. Incorporate a literature review or research on topics to support the decision to embark upon a study topic.
3. Include the names, titles, and responsibilities of all health plan staff involved in the PIP in the narrative supplied to the EQRO for review.

7.2 Validation of Performance Measures

METHODS

This section describes the documents, data, and persons interviewed for the Validation of Performance Measures for Children's Mercy Family Health Partners. Children's Mercy Family Health Partners submitted the requested documents on January 28, 2008. The EQRO reviewed documentation between January 28, 2008 and July 1, 2008. On-site review time was used to conduct follow-up questions and provide feedback and recommendations regarding the performance measure rate calculation.

DOCUMENT REVIEW

The following are the documents reviewed by the EQRO:

- The Baseline Assessment Tool (BAT) submitted by Children's Mercy Family Health Partners for the HEDIS 2007 data reporting year
- Qualis Health's NCQA HEDIS Compliance Audit Report for HEDIS 2007
- Children's Mercy Family Health Partners' information systems (IS) Policies and Procedures pertaining to HEDIS 2007 rate calculation
- Children's Mercy Family Health Partners' information services (IS) policies on disaster recovery
- Children's Mercy Family Health Partners' HEDIS committee agendas for 2007
- Children's Mercy Family Health Partners' HEDIS 2007 Training Manual for the medical record review process
- Documentation, data files and source code of the in-house application for immunization rate calculation
- System edits for the claims management system

The following are the data files submitted by Children's Mercy Family Health Partners for review by the EQRO:

- ADV_DenomNumData.txt
- ADV_EnrollmentData.txt
- AWC_DenomNumData.txt
- AWC_EnrollmentData.txt
- FUH_DenomNumData.txt
- FUH_EnrollmentData.txt

INTERVIEWS

The EQRO conducted on-site interviews with Janet Benson, IT Analyst; Johanna Groves, Senior Quality Management Nurse; Bob Clark, Director, IT/IS; and Jenny Hainey, QM Manager at the Children's Mercy Family Health Partners in Kansas City, MO on Tuesday, July 22, 2008. This group was responsible for calculating the HEDIS performance measures. The objective of the visit was to verify the data, methods and processes behind the calculation of the three HEDIS 2007 performance measures.

FINDINGS

Children's Mercy Family Health Partners used the Administrative Method for calculation of the Follow-Up After Hospitalization for Mental Illness and Annual Dental Visit measures. The Hybrid Method was used for the calculation of the Adolescent Well-Care Visit measure. MO HealthNet Managed Care health plan to MO HealthNet Managed Care health plan comparisons of the rates of Follow-Up After Hospitalization, Well-Care Visits, and Annual Dental Visit measures were conducted using two-tailed z-tests. For comparisons that were statistically significant at the 95% confidence interval (CI), the z-score (z), the upper and lower confidence intervals (CI), and the significance levels ($p < .05$) were

reported.

The rate for the HEDIS 2007 Adolescent Well-Care Visit reported to the SMA and the State Public Health Agency (SPHA) by Children's Mercy Family Health Partners was 42.82%. This was significantly higher than the statewide rate for MO HealthNet Managed Care health plans (34.81%; $z = -0.33$, 95% CI: 28.89%, 40.74%; $p > .95$). This reported rate is a significant increase over the rate (32.93%) reported by this health plan in the 2004 EQR report.

The reported rate for Children's Mercy Family Health Partners for the 2007 HEDIS Follow-Up After Hospitalization for Mental Illness was 48.50% for follow-up after 7 days. The rate reported for 7-day follow-up was comparable to the statewide rate for MO HealthNet Managed Care health plans (35.52%; $z = -0.34$, 95% CI: 22.96%, 48.08%; n.s.); this rate is significantly higher than the 7-day rate (45.15%) reported by the health plan in the 2006 EQR report. The rate reported for 30-day follow-up (88.37%) was significantly higher than the statewide reported rate for MO HealthNet Managed Care health plans (60.06%; $z = 1.38$, 95% CI: 47.50%, 72.62%; $p > .95$). This rate is also significantly higher than the 30-day rate (71.52%) reported by the health plan in the 2006 EQR report.

The HEDIS 2007 combined rate for Annual Dental Visits reported by Children's Mercy Family Health Partners was 37.49%, which is significantly higher than the statewide rate for MO HealthNet Managed Care health plans (32.50%, $z = 0.04$; 95% CI: 29.30%, 35.69%; $p > .95$). This reported rate is lower than the rate (39.09%) reported by the health plan in the 2005 EQR report.

The following sections summarize the findings of the process for validating each of the performance measures in accordance with the Validating Performance Measures Protocol. The findings from all review activities are presented according to the EQRO validation activity, with the findings for each measure

discussed within the activities as appropriate. Please refer to the tables in the main report for activities, ratings, and comments related to the CMS Protocol Attachments.

DATA INTEGRATION AND CONTROL

The information systems management policies and procedures for rate calculation were evaluated consistent with the Validating Performance Measures Protocol. This included both manual and automatic processes of information collection, storing, analyzing and reporting. The EQRO was provided with a demonstration of MedMeasures software system which was newly implemented by Children's Mercy Family Health Partners for HEDIS 2007. The accompanying MedCapture system was also demonstrated; this system allows for the calculation of the Hybrid hits from the input medical record data.

For all three measures, Children's Mercy Family Health Partners was found to meet all criteria for producing complete and accurate data (see Attachment V: Data Integration and Control Findings). There were no biases or errors found in the manner in which they transferred data into the repository used for calculating the HEDIS 2007 measures. Children's Mercy Family Health Partners used an external vendor application module for rate calculation. The EQRO was provided with a demonstration of the data flow and integration mechanisms for external databases for these measures.

DOCUMENTATION OF DATA AND PROCESSES

Data and processes used for the calculation of measures were adequate (See Attachment VII: Data and Processes Used to Calculate and Report Performance Measures). Children's Mercy Family Health Partners met all criteria applicable for all three measures. Children's Mercy Family Health Partners does utilize statistical testing and comparison of rates from year to year.

PROCESSES USED TO PRODUCE DENOMINATORS

Children's Mercy Family Health Partners met all criteria for the processes employed to produce the denominators of all three performance measures (see Attachment X: Denominator Validation Findings). This involved the selection of eligible members for the services being measured. For the Follow-Up After Hospitalization measure, a total of 301 eligible members were reported and validated by the EQRO. For the denominator of the Adolescent Well-Care Visits measure a sample of 411 eligible members were reported and validated. The Annual Dental Visit denominator included 23,806 reported and EQRO-validated eligible members. Age ranges, dates of enrollment, medical events, and continuous enrollment were programmed to include only those members who met HEDIS 2007 criteria.

PROCESSES USED TO PRODUCE NUMERATORS

All three measures included the appropriate data ranges for the qualifying events (e.g., well-care visits, follow-up visits and dental visits) as specified by the HEDIS 2007 criteria (see Attachment XIII: Numerator Validation Findings).

Children's Mercy Family Health Partners used the Hybrid Method to calculate HEDIS 2007 Adolescent Well-Care Visits measure. All 30 of the medical records requested were received; 29 records resulted in validated hybrid hits; the one record received that could not be validated showed no proof of Anticipatory Guidance. As a result, the medical record review validated 42 of the 43 hybrid hits reported. The health plan reported 133 administrative hits; of these, the EQRO was able to validate all 133. Based on the number of hits validated by the EQRO, the rate calculated was 42.47%, compared to the reported rate of

42.82%. The total estimated bias for the Adolescent Well-Care Visits measure was a 0.35% overestimate of the rate.

For the HEDIS 2007 Follow-Up After Hospitalization measure, the EQRO's review of the administrative hits validated 144 of the 146 reported by the health plan for the 7-day follow-up. The rate reported by the health plan was 48.50% and the rate calculated by the EQRO was 47.84%, with a bias of 0.66%, an overestimate by the health plan in the reporting of the measure. The EQRO validated 265 of the 266 administrative hits reported by the health plan for the 30-day follow-up measure. The rate reported by the health plan was 88.37% and the rate calculated by the EQRO was 88.04%; an overestimate bias of 0.33% by the health plan in the reporting of the measure.

Review of the administrative hits for the combined rate of the Annual Dental Visit measure validated 8,913 of the 8,926 hits found by the health plan. The rate reported by the health plan was 37.49%; the rate validated by the EQRO was 37.44%. The total estimated bias for the Annual Dental Visit measure was a 0.05% overestimate of the rate.

SAMPLING PROCEDURES FOR HYBRID METHODS

The Hybrid Method was used for the Adolescent Well-Care Visits measure. CMS Protocol Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings were completed for this measure. Children's Mercy Family Health Partners was compliant with all specifications for sampling processes.

SUBMISSION OF MEASURES TO THE STATE

Children's Mercy Family Health Partners submitted the DST for each of the three measures validated to the SPHA (the Missouri Department of Health and Senior Services) in accordance with the Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) and the SMA Quality Improvement Strategy.

DETERMINATION OF VALIDATION FINDINGS AND CALCULATION OF BIAS

The following tables summarize the estimated bias in reporting each of the measures and the final validation findings. Table 54 shows a small overestimate (inside the 95% confidence interval) for all rates.

Table 54 - Estimate of Bias in Reporting of CMFHP HEDIS 2007 Measures

Measure	Estimate of Bias	Direction of Estimate
Adolescent Well-Care Visits	0.35%	Overestimate
Follow- Up After Hospitalization (7 days)	0.66%	Overestimate
Follow-Up After Hospitalization (30 days)	0.33%	Overestimate
Annual Dental Visit	0.05%	Overestimate

FINAL AUDIT RATING

The Final Audit Rating for each of the performance measures was based on the findings from all data sources that were summarized in the Final Performance

Measure Validation Worksheet. Table 55 shows the final audit findings for each measure. All measures were Substantially Compliant, as there was no significant bias associated with the overestimated rates.

Table 55 - Final Audit Rating for CMFHP Performance Measures

Measure	Final Audit Rating
Adolescent Well-Care Visits	Substantially Compliant
Follow- Up After Hospitalization (7 days)	Substantially Compliant
Follow-Up After Hospitalization (30 days)	Substantially Compliant
Annual Dental Visit	Substantially Compliant

Note: Fully Compliant = Measure was fully compliant with State specifications; Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate; A significant bias in the rate was defined as a number calculated by the EQRO that fell outside the 95% confidence interval of the rate reported by the health plan. Not Valid = Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported; Not Applicable = No MO HealthNet Managed Care Members qualified for the measure.

CONCLUSIONS

Four rates were validated for the health plan. One of these rates was consistent with; and three were significantly higher than the average for all MO HealthNet Managed Care health plans.

QUALITY OF CARE

Children's Mercy Family Health Partner's calculation of the HEDIS 2007 Follow-Up After Hospitalization for Mental Illness measure was substantially compliant with specifications. This measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care delivered. The health plans 7-day follow-up rate was consistent with the overall MO HealthNet Managed Care health plans calculated rate, and 30- day follow up rate for this measure was significantly higher than the average for all MO HealthNet Managed Care health plans. Both of these rates were also significantly higher than the same measure rates reported in last year's EQR report. The plan's focus on this measure is evident in the results they have achieved in these rates.

Therefore, Children's Mercy Family Health Partners' members are receiving a quality of care for this measure at or above the level than the care delivered to the average MO Health Net Managed Care member. Additionally, both of these rates were reported as higher than the National Medicaid Rate, and the 30-day rate was higher than the National Commercial Rate. Therefore, CMFHP is delivering a higher level of quality than that received by the average Medicaid member across the nation, and a higher level of quality for the 30-day timeframe than is received by the average Commercial member across the nation.

The EQRO was able to validate this rate within the reported 95% confidence interval and thereby has substantial confidence in the calculated rate.

ACCESS TO CARE

The calculated rate by Children's Mercy Family Health Partners for the HEDIS 2007 Annual Dental Visit rate was substantially compliant with specifications; this measure is categorized as an Effectiveness of Care measure. Because only one visit is required for a positive "hit", this measure effectively demonstrates the level of access to care that members are receiving. Although the health plan's reported rate for this measure was significantly higher than the average for all MO HealthNet Managed Care health plans, the rate is slightly lower than the rate reported by the health plan in 2005. However, CMFHP members are receiving a quality of care that is higher than the level of care delivered to the average MO HealthNet Managed Care member.

The EQRO was able to validate this rate within the reported 95% confidence interval and thereby has substantial confidence in the calculated rate.

TIMELINESS OF CARE

The health plan's calculation of the HEDIS 2007 Adolescent Well-Care Visits measure was substantially compliant. This measure is categorized as a Use of Services measure and is designed to measure access to and timeliness of the care defined. The health plan's reported rate for this measure was significantly higher than the average for all MO HealthNet Managed Care health plans; this rate was also slightly higher than the rate reported by the health plan in 2004. Therefore, Children's Mercy Family Health Partners' members are receiving the timeliness of care for this measure at a higher level than the care delivered to all other MO HealthNet Managed Care members. This rate was also higher than the National Commercial Rate, showing that Children's Mercy Family Health

Partners' members are receiving the timeliness of care for this measure at a higher level than the average Commercial member across the nation.

The EQRO was able to validate this rate within the reported 95% confidence intervals and thereby has confidence in the calculated rate.

RECOMMENDATIONS

1. Continue to conduct and document statistical comparisons on rates from year to year.
2. Continue to utilize the Hybrid methodology for calculating rates when allowed by the specifications.
3. The health plan experienced a reduction in the Annual Dental Visit rate between the rate reported in 2005 and the rate reported for 2007; the EQRO recommends that the health plan focus on this rate to reverse this trend.

7.3 Validation of Encounter Data

FINDINGS

The findings for the encounter data validation are organized according to the encounter data evaluation questions presented in the Technical Methods section for the encounter data validation in the aggregate report. Please refer to the main report for detailed objectives, technical methods and procedures for encounter data validation.

What is the Baseline Level of Completeness, Accuracy, and Reasonableness of the Critical Fields?

For the Medical claim type, there were 107,242 encounter claims paid by the SMA for the period July 1, 2007 through September 30, 2007.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Outpatient Recipient ID field was 100.00% complete, accurate and valid.
3. The Outpatient First Date of Service field was 100.00% complete, accurate and valid.
4. The Outpatient Last Date of Service field was 100.00% complete and accurate, and valid.
5. The Outpatient Units of Service field was 100.00% complete accurate and valid.
6. The Outpatient Procedure Code field was 99.99% complete accurate and valid. The remaining field (n=1) was blank (incomplete, inaccurate and invalid).
7. The Outpatient Place of Service field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 100.00% complete, accurate and valid.
9. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, the second, third, and

fourth Diagnosis Code fields were well below the SMA threshold of 100.00% completeness, accuracy and validity. The second, third, fourth and fifth Diagnosis Code field were (44.94%, 0.30%, 0.00%, and 0.00%) complete, accurate and valid, respectively. The remaining fields were blank (incomplete, inaccurate, and invalid).

For the Dental claim type, there were 19,718 encounter claims paid by the SMA for the period July 1, 2007 through September 30, 2007. All fields were 00.00% complete, accurate and valid.

For the Home Health claim type, there were zero (0) encounter claims paid by the SMA for the period July 1, 2007 through September 30, 2007.

For the Inpatient claim type, there were 12,898 encounter claims paid by the SMA for the period July 1, 2007 through September 30, 2007.

1. The Inpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Recipient ID field was 100.00% complete, accurate and valid.
3. The Admission Type field was 100.00% complete, accurate and valid.
4. The Admission Date field was 100.00% complete and accurate; and valid.
5. The Discharge Date field was 100.00% complete and accurate and valid.
6. The Bill Type field was 100.00% complete, accurate and valid.
7. The Patient Status field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 100.00% complete, accurate and valid.
9. All other Diagnosis Code fields fell well below the 100% threshold for completeness, accuracy, and validity established by the SMA. The second, third, fourth, and fifth Diagnosis Code fields were 90.64%, 0.77%, 0.0%, and 0.0% complete, accurate and valid, respectively. The remaining fields were blank (incomplete, inaccurate, and invalid).
10. The First Date of Service field was 100.00% complete, accurate and valid.
11. The Last Date of Service field was 100.00% complete, accurate and valid.

12. The Revenue Code field was 100.0% complete, accurate, and valid.

13. The Units of Service field was 100.00% complete, accurate and valid.

For the Outpatient Hospital claim type, there were 76,460 encounter claims paid by the SMA for the period July 1, 2007 through September 30, 2007.

1. The Outpatient Hospital Claim Type field was 100.00% complete, accurate and valid.
2. The Recipient ID field was 100.00% complete, accurate and valid.
3. The First Date of Service field was 100.00% complete and accurate, and valid.
4. The Last Date of Service field was 100.00% complete and accurate, and valid.
5. The Units of Service field was 100.00% complete, accurate and valid.
6. The Outpatient Procedure Code field was 98.31% complete and accurate, and 97.85% valid. This field requires five alphanumeric characters. There were 1,290 blank fields and 352 invalid fields.
7. The Outpatient Hospital Revenue Code field was 100.00% complete and accurate, and valid.
8. The first Diagnosis Code field was 100.00% complete, accurate and valid.
9. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, the second, third, fourth, and fifth Diagnosis Code fields were well below the 100% threshold for completeness, accuracy and validity set by the SMA. The second, third, fourth and fifth Diagnosis Code fields were 57.38%, 0.04%, 0.0% and 0.0% complete, accurate and valid, respectively. The remaining fields were blank (incomplete, inaccurate, and invalid).

For the Pharmacy claim type, there were 27 claims paid by the SMA for the period July 1, 2007 through September 30, 2007. All fields examined were 100.00% complete, accurate and valid data for all fields examined. It is important to note that the MCHP had pharmacy claims "carved-out" of their

contract with the SMA that began on July 1, 2007. This explains the extremely low numbers of encounter claims during the time period reviewed.

What Types of Encounter Claim Data are Missing and Why?

Based on the above analysis of the accuracy, completeness, and validity of the data in the SMA encounter claims extract file for Family Health Partners, an error analysis of the invalid entries was conducted for fields which were lower than the 100.00% threshold specified by the SMA. The critical fields examined for the Dental and Pharmacy claim type fields were 100.00% complete, accurate, and valid (see previous findings). The Outpatient Procedure Code fields in the Medical and Hospital claim types contained invalid procedure codes.

What is the Level of Volume and Consistency of Services?

When comparing the rate of encounter claim types per 1,000 members, the rates of Inpatient, Medical and Hospital claim types were consistent with the average for all MO HealthNet Managed Care health plans, while the rates for Dental claim types were significantly higher than the average for all MO HealthNet Managed Care health plans. This suggests that the data are complete and that there is better utilization of dental services and high rates of access to preventive and acute care among Children's Mercy Family Health Partners members.

To What Extent do the Claims in the State Encounter Claims Database Reflect the Information Documented in the Medical Record? What is the Fault/Match Rate between State Encounter Claims and Medical Records?

To examine the degree of match between the SMA encounter claims database and the medical record, 100 encounters from each MO HealthNet Managed Care health plan were randomly selected from Medical claim types for the period of July 1, 2007 through September 30, 2007 for medical record review. Of the 216,345 encounter claim types in the SMA extract file for July 1, 2007 through September 30, 2007, 100 encounters were randomly selected. Providers were requested to submit medical records for review. There were 88 medical records (88.0%) submitted for review. Encounters for which no documentation was submitted were unable to be validated. The match rate for procedures was 51.0%, with a fault rate of 49.0%. The match rate for diagnoses was 47.0%, with a fault rate of 53.0%.

What Types of Errors Were Noted?

An error analysis of the errors found in the medical record for procedure and diagnosis codes was conducted. For the diagnosis code in the medical record, the reasons for diagnosis codes not matching the SMA extract file was missing information (n =53) with no incorrect information. The diagnosis code listed did not match the descriptive information in the record.

For the procedure code in the medical record, the reasons for procedure codes in the SMA extract file not being supported by documentation in the medical record were missing information (n = 38), incorrect (n=7), downcoding (n=2) and upcoding (n=4). Examples of missing information included no code, codes listed that were not supported, or codes that did not match the procedure description.

What Problems are there with How Files are Compiled and Submitted by the MO HealthNet MCHP?

Since Children's Mercy Family Health Partners included internal control numbers that matched those of the SMA, the EQRO conducted the planned analyses comparing MO HealthNet Managed Care health plan encounter data to the SMA encounter claim extract file. The SMA defined "unpaid claims" as those claims that the MCHP denied for payment, unpaid claims do not include claims paid via a capitation plan.

MO HealthNet Managed Care health plans were requested to submit data, as specified by the EQRO (see Appendix 6), for the Members represented in the encounter claim sample selected for validation.

For the Pharmacy Claim type, all encounter data submitted to the EQRO was of "paid" status. There were 0 unmatched claims that were in the CMFHP encounter file and absent from the SMA data.

For all Outpatient Claim Types (Medical, Dental, Home Health and Hospital), CMFHP submitted 203,420 "paid" encounters and 259 "denied" claims. All paid encounter claims matched with the SMA encounter claim extract file. The 259 denied claims were not present in the SMA database (as expected); there was a "hit" rate of 99.99% between CMFHP's encounter claims and the SMA encounter data.

For the Inpatient Claim Type, CMFHP submitted 12,898 encounter claims of "paid" status and 228 "denied" claims. All paid encounter claims matched with the SMA encounter claim extract file. The denied claims were not present in the SMA database. This produced a "hit" rate of 98.23% between CMFHP's encounter claims and the SMA encounter data.

Why are there unmatched claims between the MCHP and SMA data files?

The unmatched encounters are due to missing ICN numbers which are required to match the encounter to that of the SMA. Therefore, in all claim types, the encounter claims were legitimately missing from the SMA extract data.

What are the Data Quality Issues Associated with the Processing of Encounter Data?

While the MO HealthNet Managed Care health plan did submit the data in the requested format (including most ICN numbers), there are a number of ways to improve the data quality by improving the database system. As the Internal Control Number is only assigned by the State database when a claim is paid, it is difficult to match the MO HealthNet Managed Care health plan data of "unpaid" and "denied" claims to the SMA data. As the Internal Control Number is unique only to the encounter, the ICN may be represented in multiple lines of data. To match the MO HealthNet Managed Care health plan data to the SMA data to specific fields, this requires a unique line number. Therefore each service provided within an encounter would have a separate line of data with a unique line identifier.

CONCLUSIONS**STRENGTHS**

1. Encounter data was submitted to the EQRO in the requested format which allowed encounter validation for all claim types.
2. The critical field validation of all six claim types resulted in few fields under the SMA established threshold of 100.00% accuracy, completeness, and validity.
3. The critical fields evaluated for the Outpatient Medical, Dental and Pharmacy claim types were 100.00% complete, accurate, and valid.
4. The rate of Dental claim types were significantly higher than the average for MO HealthNet Managed Care health plans, suggesting high rates of encounter data submission and at least moderate access to preventive and acute care.

AREAS FOR IMPROVEMENT

1. The Outpatient Procedure Code fields in the Outpatient Hospital claim type contained invalid codes.
2. The match rate between the medical record and SMA encounter claims data was comparable to the average for all MO HealthNet Managed Care health plans for the procedure code.
3. The MCO reported no Home Health encounter claims during the review period.

RECOMMENDATIONS

1. Examine and revise as needed internal system edits for invalid procedure codes in the NSF/CMS 1500 file layout for the Outpatient Procedure Code and run validity checks after the programming of new edits.
2. Ensure that the Inpatient Admission Date, Discharge Date and Revenue Code fields are complete and valid for the Inpatient claim types, and institute error checks to identify invalid data.

7.4 MO HealthNet MCHP Compliance with Managed Care Regulations

METHODS

Prior to the site visit, documentation was received and reviewed regarding the MO HealthNet Managed Care Health Plan's compliance with the State contract. The External Quality Review Organization (EQRO) reviewed contract documents with the staff of the MO HealthNet Division (MHD). On-site review time was used to conduct interviews with those who oversee the daily practices of the health plan. This ensures that documentation is developed and practices occur within the scope of the contract and in a manner that meets or exceeds federal regulations.

A detailed protocol (BHC MO HealthNet Managed Care Health Plan Compliance Review Scoring Form) was utilized to ensure that all the elements of the federal regulations were addressed in the review process. Additionally, an interview tool was constructed to validate practices that occur at the health plan, through interviews with Member Services and Case Management staff members. Follow-up on questions raised from the document review and requests for clarification on responses received in staff interviews were presented during a final interview with plan administrative staff. Document reviews occurred on-site to validate that practices and procedures were in place to guide organizational performance.

DOCUMENT REVIEW

The following documents pertaining to Children's Mercy Family Health Partners were reviewed prior to and at the on-site visit:

The MO HealthNet Division supplied:



- State of Missouri Contract Compliance Tool (including MHD responses and comments)

The following documents were requested for on-site review:

- Member Handbook
- Provider Handbook
- 2007 Marketing Materials
- Credentialing Policy and Annual Audit Reports
- Policy Tracking Log
- Staff Training Records
- Grievance and Appeal Logs
- 2007 Annual Quality Improvement Program Evaluation

Additional documentation made available by Children's Mercy Family Health Partners included:

- 2007 Marketing Plan
- Children's Mercy Family Health Partners' Organizational Chart
- 2007 Welcome Calls summary by Quarter
- Connection – Member Newsletter
- New Directions Behavioral Health – Referral to the Prevention Team Policy & Care Coordination Referral, Evaluation, and Acceptance Policy
- Screening Tool for Outreach Coordinator
- Special Health Care Needs Policy (CMFHP)
- "Bringing It Together" – 2007 Missouri Community Report

INTERVIEWS

Interviews were conducted with the following group:

Plan Administration

- Robert Finuf – Chief Executive Officer, Plan Administrator
- Ma'ata Touslee – Director of Health Services
- Jenny Hainey – Manager, Quality Management

- Kathy Ripley-Hake – Director, Provider Relations
- Juanita Prieto – Manager, Provider Relations
- Cindy Mense – Director, Customer Relations
- Chris Beurman – Manager, Community Relations
- Lisa Gabel – Manager, Clinical Services
- Chad Moore – Compliance Officer
- Dr. Elizabeth Peterson – Medical Director

Member Services Staff

- Ma'ata Touslee – Director of Health Services
- Mark Van Blaricum – Compliance Officer
- Cindy Mense – Director, Customer Relations
- Steve Cupp – Member Services Staff
- Paula McFall – New Directions Member Services

Case Management Staff

- Ma'ata Touslee – Director of Health Services
- Mark Van Blaricum – Compliance Officer
- Christy Roberts – Supervisor, Care Management
- Amanda Caron – Case Management Outreach Coordinator
- Alice Creager – Case Manager
- Melody Dirks – Case Manager
- Stephana McCullough – Case Manager

FINDINGS

ENROLLEE RIGHTS AND PROTECTIONS

The staff at Children's Mercy Family Health Partners (CMFHP) continued to exhibit a strong commitment to ensuring that member rights were protected. The health plan utilized interpreter services, pre-translated written materials and a variety of methods for those members who spoke a language other than English. The health plan provides alternatives to members who may have reading, vision, or hearing problems enabling them to obtain required information about the health plan or the services they can expect to receive. Member Services staff set up alternatives for individuals with any barrier to obtaining services and worked diligently to ensure that they receive necessary assistance.

During 2005, CMFHP developed a tracking system to guarantee that all required materials and policy are reviewed on an annual basis, as required, and are submitted to the SMA in a timely manner. This process continued to be used during the 2006 and 2007 program years. This information continues to be reviewed on a monthly basis and is stored in a locally maintained Access database. A quality committee reviews the database information quarterly to ensure that all updates occurred timely. Member education and marketing materials were all submitted and approved early in 2007.

CMFHP worked with an external contractor to develop applications of the ManagedCare.com software for their health information system. The company, using an internal utilization management committee, initially looked at all parts of the CMFHP system and narrowed the initial focus to ten areas. The ManagedCare.com database was implemented and operational in 2006. The system produces monthly analysis, trends, and utilization information that is initially used by Utilization Management. Trend analysis is provided to managers on a monthly basis. These reports have been an important tool for managers in relation to both member and provider services.

During 2005 the CMFHP Member Advisory Committee was established. During 2006 the health plan admits that they have struggled in maintaining regular attendance by members. They have provided transportation and other incentives with little success. Several ideas for membership based on information from other MO HealthNet Managed Care health plans were provided and included foster parents and the use of a former member who may have more resources currently and be able to attend. The health plan exhibited its strong commitment to the advisory committee members and continues to send reminders. During the 2007 review it was learned that the health plan has added consumer advocates as committee members to enhance community generated information. Membership on this committee now includes school nurses, social workers, Head Start teachers, and Parents as Teachers advocates. Quarterly meetings of this group are continuing and attendance has improved significantly. Topics of these meetings included disease management programs and benefits. Information from the presentation was included in a member newsletter, at the recommendation of a committee member. The committee has made suggestions, such as changing marketing brochures, which have been implemented. Their advice and recommendations will be considered and utilized whenever possible.

Children's Mercy Family Health Partners continues to participate in community events including back-to-school fairs, work with area churches, the Chamber of Commerce, and events targeting the Latino and African American communities. They work with two groups specifically, El Central and CoHo. A Latino staff member attends many of these events to ensure appropriate information is shared with members about access to care. The local Latino radio station interviews staff and uses this information to promote events for their listeners.

The YMCA posts information that reaches a number of minority communities in

the area. Free swimming is provided by Parks and Recreation and up to 500 individuals attended one event at Swope pool. The health plan provides healthy snacks, and information on available services and local providers. The Case Managers participate monthly in a "concerned clergy" radio program sponsored by the "Ministerial Alliance" of African American pastors. This provides additional information on healthcare services to the community, as well as education to members on the availability of providers and supportive services.

Six Member Service representatives attended the interview. The discussion was spirited and displayed a sense of pride in the assistance this team provides to health plan members. They stressed that members are informed that they can utilize a PCP anywhere in the CMFHP Network. Methods were described that ensured the members who do not speak English are served adequately. Member Services phones are equipped with a Spanish access key, and the health plan employs staff who speak Spanish. These staff exhibited a commitment to ensure that members are happy with their health care, and that they are willing to do extra work to ensure that the member has a PCP they can trust, and are receiving the services available to them. The staff stressed that they ensure that members are aware of all plan benefits, including transportation. During the interview, one staff member shared that the previous day they contacted a member, who has missed several appointments, to ensure that this member was aware of transportation services, and to identify other barriers to receiving services that might exist.

Case Managers explained that they receive referrals formally and informally. They explore the listing received monthly from the SMA to identify all children with special health care needs. They also receive referrals from providers, WIC, health fairs, Customer Services, OB risk assessment forms, pre-certification, utilization review, and from members themselves. The case managers stated that 80% of the Jackson County foster children utilize CMFHP as their designated

health plan. Efforts were made in 2007 to enhance referrals for case management through Lunch and Learn Meetings at high volume obstetric offices. These efforts are viewed as successful and have continued in 2008.

When a new referral is received it is reviewed within 48 hours. A review of utilization activity and claims activity is performed. A parent may be called for information and clarification if a child is involved. The case manager meets with the member, completes an assessment and formulates a treatment plan. Permission is obtained from parents when a care plan is written for a child. Case Managers are aware that a member may refuse these services. If a refusal occurs the case managers work within the system to assist the member without direct contact being required. The case managers also utilize a contract they have with Verizon, who provides mobile telephones. These phones can be programmed so that the member can only make calls to the case manager, transportation services, Pharmacy, mental health, the pharmacy and/or 911. Bills are then reviewed to ensure that members are making contacts appropriately.

Ratings for Compliance with Enrollee Rights and Protections (100%) reflected policy and procedures that were submitted to and approved by the SMA for the third consecutive year. All written information has been submitted and approved. All practice observed, as well as additional documentation viewed while on-site, indicated that the health plan is fully compliant in this area.

Table 56 – Subpart C: Enrollee Rights and Protections Yearly Comparison (CMFHP)

Federal Regulation	CMFHP		
	2005	2006	2007
438.100(a) Enrollee Rights: General Rule	2	2	2
438.10(b) Enrollee Rights: Information Requirements	2	2	2
438.10(c)(3) Alternative Language: Prevalent Language	2	2	2
438.10(c)(4,5) Language and Format: Interpreter Services	2	2	2
438.10(d)(1)(i) Information Requirements: Format/Easily Understood	2	2	2
438.10(d)(1)(ii) and (2) Information Requirements: Format Visually Impaired, and Limited Reading Proficiency	2	2	2

438.10(f) Information for All Enrollees: Free Choice, etc.	2	2	2
438.10 (g) Information to Enrollees: Specifics/Physician Incentive Plans	2	2	2
438.10(i) Special Rules: Liability for Payment/Cost Sharing	2	2	2
438.100(b)(2)(iii) Enrollee Rights: Provider-Enrollee Communications	2	2	2
438.100(b)(2)(iv,v) Rights to Refuse Services/Advance Directives	2	2	2
438.100(b)(3) Right to Services	2	2	2
438.100(d) Compliance with Other Federal/State Laws	2	2	2
Number Met	13	13	13
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	100.0%

Note: 0 = Not Met; 1= Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols.

BEHAVIORAL HEALTH

CMFHP began contracting with New Directions Behavioral Health (NDBH) for the provision of behavioral health services for members during 2007. Interviews included a Member Services representative for NDBH. The approach to Member Services and case management by the BHO is very supportive of members, accepting of the need to provide adequate services, and doing so in a timely manner. NDBH is known for providing in-home services, and for contracting with a local provider who provides intensive in-home treatment for members to ensure that the family has a full array of in-home services and support. This service is extraordinary to those expected by the MO HealthNet Managed Care contract. These services are available to CMFHP members. The relationship between the health plan and the BHO is collaborative and the examples provided indicate that it is very member focused.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT**Access Standards**

CMFHP continued to have a strong provider network throughout the Western Region. The health plan has worked one-on-one with providers, including specialists who agreed to become panel members. The health plan recognizes a continued need for neurosurgeons and orthopedic surgeons. CMFHP recruited several specialists who agreed to be in the network, but requested to remain silent and not be published in the Provider Manual. These providers saw members when contacted directly by health plan staff. CMFHP paid a higher fee to OB, orthopedic surgeons, urologists, and neurologists outside of Truman Medical Center staff to ensure adequate access to these specialties. The health plan engaged Truman Medical Center in this process, to ensure that members were triaged and received a referral and provider access quickly. CMFHP continued to monitor their PCP availability and continued recruitment to ensure that adequate open panels were available.



Member Services staff reports that they do receive calls requesting PCP changes. The health plan began tracking members who requested changes in PCPs, pharmacy data, and emergency room utilization to identify if drug seeking was a contributor to this problem. The monitoring produced some useful information. Several members chronically missed appointments and were asked to find a new physician. The health plan continues monitoring efforts to identify problems and to address them quickly and efficiently.

The health plan continues to use member surveys and on-site reviews to monitor access standards. When deficiencies were identified they were dealt with in writing. Direct provider contact occurred where required. Re-audits occurred to ensure that improvement was sustained.

Member Services staff reports that they assist members with a number of access issues. They supply information on available providers and their location. They instruct members on utilization of the handbook to identify providers, including those that speak other languages or provide special services. If a provider contract is terminated, members receive a letter. Follow-up by telephone occurs, particularly if a member's information indicates that they have literacy difficulties. Staff also discussed the efforts they make to assist member in obtaining copies of their medical records. If there is a problem with provider compliance, the Member Services staff intervenes, but also makes a referral to Provider Relations for follow-up.

Case Managers also become involved in assisting members in accessing appropriate medical care. They ensure coordination of services, and ensure that all levels of health care required are available. The CMFHP case managers meet quarterly with BHO case managers to ensure that they are serving clients appropriately when they have multiple service needs. Case managers also receive a listing twice a year that identifies all members who have not seen their

PCP in a year. Contact is made by letter, and additional outreach occurs to ensure that health care services are received, and to identify changes that may be needed.

Ratings for compliance with Access Standards (100%) reflected completion of all required written policies and procedures for the third consecutive year.

Observations and interviews that occurred during the on-site review provided additional evidence that health plan practices and operations appear to be compliant with the MO HealthNet Managed Care Contract and federal regulations.

Table 57 – Subpart D: Quality Assessment and Performance Improvement: Access Standards Yearly Comparison (CMFHP)

Federal Regulation	CMFHP		
	2005	2006	2007
438.206(b)(1)(i-v) Availability of Services: Provider Network	2	2	2
438.206 (b) (2) Access to Well Woman Care: Direct Access	2	2	2
438.206(b)(3) Second Opinions	2	2	2
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	2	2	2
438.206(b)(5) Out of Network Services: Cost Sharing	2	2	2
438.206(c)(1)(i-vi) Timely Access	2	2	2
438.206(c)(2) Provider Services: Cultural Competency	2	2	2
438.208(b) Care Coordination: Primary Care	2	2	2
438.208(c)(1) Care Coordination: Identification	2	2	2
438.208(c)(2) Care Coordination: Assessment	2	2	2
438.208(c)(3) Care Coordination: Treatment Plans	2	2	2
438.208(c)(4) Care Coordination: Direct Access to Specialists	2	2	2
438.210(b) Authorization of Services	2	2	2
438.210(c) Notice of Adverse Action	2	2	2
438.210(d) Timeframes for Decisions, Expedited Authorizations	2	2	2
438.210(e) Compensation of Utilization Management Activities	2	2	2
438.114 Emergency and Post-Stabilization Services	2	2	2
Number Met	17	17	17
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	100.0%

Note: 0 = Not Met; 1= Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols.

Structures and Operation Standards

CMFHP members have open access to specialists, with no referral from the PCP required. In some cases members receive assistance with referrals from health plan case managers. When a member has a specific problem, and care coordination is needed between clinicians, this service is provided by the appropriate case manager. The health plan initiated a formal means of facilitating communication between PCPs and specialists in 2006. They report that letters detailing care provided flow between the two. Case managers facilitate this communication, with member approval, to ensure that pertinent information is shared.

CMFHP formed a committee during 2007 to discuss the best methodology for making information about advance directives available to members. The goal was to have this information available at PCP offices. Education and materials were provided to PCPs on this topic. Two areas that remained problematic were accurate completion of all required documentation and proper recording in medical records. The health plan continues to work with PCP offices to improve these areas.

CMFHP credentialing policies were reviewed. NCQA standards are followed. Site visits and record keeping reviews are conducted on initial credentialing of PCPs and OB/GYNs. Re-credentialing is conducted every three years. Sanctions and quality are reviewed monthly. Credentialing policies and procedures were approved by the health plan oversight committee, and were approved by the SMA in June 2006. Information reviewed indicated that a delegated review of Truman Medical Center occurred and no deficiencies were identified.

Bridgeport, the dental subcontractor, was the subject of a delegated audit in July 2005 and no deficiencies were found. All these policies and procedures were continued during 2007.

The case managers continued to participate in an OB forum that began in 2005. They report having three or four successful meetings with good information sharing between case management staff and physicians attending. The Case Managers attend a forum in St. Louis annually. This has been a helpful tool in expanding their knowledge about issues that confront members.

Member Services staff discussed their awareness of issues such as members requesting disenrollment. They do enter these requests into the health plan's system, and assist the member through the process. Reason codes are tracked and reviewed at Oversight Committee meetings. They also seek feedback from the SMA regard disenrollment information to ensure that adjustments and changes are made if a service delivery issue is the cause of these requests.

The ratings for compliance with Structure and Operation Standards (100%) reflected complete policy and procedural requirements for the third consecutive year. The health plan appears to be compliant with all policy and practice in this area that meets SMA contract compliance and federal regulations.

Table 58 – Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison (CMFHP)

Federal Regulation	CMFHP		
	2005	2006	2007
438.214(a,b) Provider Selection: Credentialing/Recertification	2	2	2
438.214(c) and 438.12 Provider Selection: Nondiscrimination	2	2	2
438.214(d) Provider Selection: Excluded Providers	2	2	2
438.214(e) Provider Selection: State Requirements	2	2	2
438.226 and 438.56(b)(1-3) Disenrollment: Requirements and limitations	2	2	2
438.56(c) Disenrollment Requested by the Enrollee	2	2	2
438.56(d) Disenrollment: Procedures	2	2	2
438.56(e) Disenrollment: Timeframes	2	2	2
438.228 Grievance System	2	2	2
438.230(a,b) Subcontractual Relationships and Delegation	2	2	2
Number Met	10	10	10
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	100.0%

Note: 0 = Not Met; 1 = Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols.

Measurement and Improvement

CMFHP continued to be an active member of the Kansas City Quality Improvement Consortium (KCQIC) and utilized the practice guidelines developed and supported by that group. The local guidelines that were used by the health plan continued to meet or exceed nationally accepted standards. The KCQIC has developed guidelines on obesity treatment. CMFHP is now using these guidelines. The health plan continued to utilize Milliman and Roberson guidelines for utilization management.

CMFHP continues to send providers a quarterly report card covering lead and EPSDT rates. This is used as an incentive to increase the screening rates. Solo practice PCPs have the best rates in the health plan. They are reporting completion rates of 77%-84%. The health plan is discussing adding additional HEDIS components to the report card in the future.

CMFHP did submit two Performance Improvement Projects (PIPs) for validation. Specific details of these projects can be found in the appropriate section of the report. It was noted that the health plan utilized projects that had been started, and perfected these projects in an effort to create improved services to members during the measurement year. These PIPs were well-constructed and provided adequate information for validation.

The health plan submitted all required information to complete the Validation of Performance Measures, as requested. CMFHP continued to operate a health information system within the guidelines of that protocol. All encounter data requested was provided in the correct format. The details of each of these areas of validation can be reviewed within specific sections of this report.

Neither Case Managers or Member Services staff report having involvement in this portion of health plan operations. They were asked if members ever

requested practice guidelines. Both replied that they had not, but that if this occurred, or there was an identified need, this information would be shared with members.

Ratings for the Measurement and Improvement sections were found to be (100%), which reflects that all required policy and practice meets the requirements of the MO HealthNet Managed Care contract and the federal regulations for the third consecutive year.

Table 59 – Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement Yearly Comparison (CMFHP)

Federal Regulation	CMFHP		
	2005	2006	2007
438.236(b)(1-4) Practice Guidelines: Adoption	2	2	2
438.236(c) Practice Guidelines: Dissemination	2	2	2
438.236(d) Practice Guidelines: Application	2	2	2
438.240(a)(1) QAPI: General Rules	2	2	2
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCO Quality Improvement and PIPs	2	2	2
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	2	2	2
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	2	2	2
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	2	2	2
438.240(e) QAPI: Program Review by State	NA	NA	NA
438.242(a) Health Information Systems	2	2	2
438.242(b)(1,2) Health Information Systems: Basic Elements	2	2	2
438.242(b)(3) Health Information Systems: Basic Elements	2	2	2
Number Met	11	11	11
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	100.0%

Note: Regulation 438.240(e) refers to program review by the state. The regulation requires the state to review, at least annually, the impact and effectiveness of each MCHP's quality assessment and performance improvement program. The regulation refers to the state QA & I program review process and is not applicable to External Quality Review of the MC+ Managed Care Program. This percent is calculated for the regulations that are applicable to the MC+ Managed Care Program. 0 = Not Met; 1 = Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols.

Grievance Systems

Ratings for compliance with the Grievance Systems regulations (100%) indicate that the health plan completed all requirements regarding policy and practice. This is the fourth consecutive year that the health plan is fully compliant in this section of the review.

An update occurred in the health plan's claims system during 2006. This resulted in a decrease in provider complaints. There was an inappropriate edit in the system causing complaints that resulted in a number of overturned decisions. This edit was removed and replaced with an appropriate edit and complaints decreased significantly. Timeframes for authorizations were extended to 14 days, as needed to obtain additional information. This decreased denials and provider complaints as well. Currently the health plan has maintained a very low denial rate.

Member Services staff was aware of the grievance process and related that they do provide assistance to members who contact them with concerns. When a member calls, the staff try to assist them so they know what questions to ask, and how to get answers to these questions throughout the grievance process. If a member does not realize that their concern is a grievable issue, the staff advises them further on negotiating this system and the importance of filing a grievance.

Case Managers report that they become involved when members receive an adverse authorization decision. The case managers then refer the member to the Grievance/Appeal Department. Case managers are aware that the information is available in the Member Handbook, but assist members in any way that they can.

Table 60 – Subpart F: Grievance Systems Yearly Comparison (CMFHP)

Federal Regulation	MCP		
	2005	2006	2007
438.402(a) Grievance and Appeals: General Requirements	2	2	2
438.402(b)(1) Grievance System: Filing Requirements - Authority	2	2	2
438.402(b)(2) Grievance System: Filing Requirements - Timing	2	2	2
438.402(b)(3) Grievance System: Filing Requirements - Procedures	2	2	2
438.404(a) Grievance System: Notice of Action - Language and Format	2	2	2
438.404(b) Notice of Action: Content	2	2	2
438.404(c) Notice of Action: Timing	2	2	2
438.406(a) Handling of Grievances and Appeals: General Requirements	2	2	2
438.406(b) Handling of Grievance and Appeals: Special Requirements for Appeals	2	2	2
438.408(a) Resolution and Notification: Basic Rule	2	2	2
438.408(b,c) Resolution and Notification: Grievances and Appeals - Timeframes and Extensions	2	2	2
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	2	2	2
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	2	2	2
438.410 Expedited Resolution of Appeals	2	2	2
438.414 Information about the Grievance System to Providers and Subcontractors	2	2	2
438.416 Recordkeeping and Reporting Requirements	2	2	2
438.420 Continuation of Benefits while Appeal/Fair Hearing Pends	2	2	2
438.424 Effectuation of Reversed Appeal Resolutions	2	2	2
Number Met	18	18	18
Number Partially Met	0	0	0
Number Not Met	10	0	0
Rate Met	100%	100%	100%

Note: 0 = Not Met; 1 = Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols

CONCLUSIONS

Children's Mercy Family Health Partners continues their strong commitment to meeting all policy, procedure, and practice areas of compliance with both the MO HealthNet Managed Care contract requirements and the federal regulations. The health plan exhibits a meticulous attention to meeting all the details of the regulations, submitting policy and procedural updates in a timely fashion, and utilizing the prior External Quality Reviews as a guideline for meeting required standards. The CMFHP staff exhibit a sincere commitment to excellence in serving MO HealthNet Managed Care members. They demonstrated respect and dignity toward members, while meeting their healthcare service needs efficiently and effectively. The health plan goes beyond the strict requirements of their contract to ensure that members are able to have a voice in the design of their healthcare system. The system created at CMFHP is responsive and strives to assist its members in overcoming the barriers often encountered in the areas of quality, access and timeliness in obtaining healthcare services.

QUALITY OF CARE

CMFHP has initiated a number of programs to ensure that members from the diverse population in their area have access to providers and information in their language and in a manner that is understandable to them. They work diligently to ensure that providers are serving members in a quality manner. The health plan monitors their service delivery system, including providers, regularly to produce quality services from the organization, and from the healthcare providers involved. CMFHP has demonstrated a number of creative approaches to engaging providers, particularly in hard-to-reach specializations. They actively engage new health management programs to benefit members. The health plan has a strong relationship within the community and obtain feedback on their programs to ensure that quality care and services are achieved.



ACCESS TO CARE

Children's Mercy Family Health Partners demonstrates its commitment to ensuring access to care to members throughout their organization. Their focus on development and utilization of a Member Advisory Committee to ensure that members have a forum to discuss access issues directly with the health plan is a primary example. Their willingness to assist members' attendance, by creating reminders and providing transportation highlights this effort. The health plan demonstrates its sincerity in these efforts by implementing suggestions that come from these meetings. The health plan has also made many accommodations to ensure that members have access to the array of specialists they require to obtain quality healthcare services.

TIMELINESS OF CARE

The health plan has ensured that the treatment of members and providers during the grievance and appeal process is of primary importance. They examine the reasons for grievances and appeals to ensure that their processes are not causing a problem. If this is the case, the health plan is willing to take steps to rectify the problem, thus ensuring that timely care takes place for members. CMFHP continues their vigilant attention to continuous improvement within the organization and attention to improving services to members.

RECOMMENDATIONS

1. Continue to develop an organization that can exhibit energy and enthusiasm for its mission.
2. Continue to actively monitor providers and subcontractors and to develop corrective action initiatives when a problem is identified, such as advance directive utilization.
3. Continue to look for creative methods to use as motivators, such as

available incentives, to encourage member utilization of health plan resources, particularly for high-risk populations.

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8.0 Harmony Health Plan of Missouri

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8.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

Harmony Health Plan supplied the following documentation for review:

- 2007 Medical Record Documentation by Primary Care Physicians and Their Staff, Interventions and Their Efficacy
- 2007 Lead Screening

INTERVIEWS

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on July 10, 2008 during the on-site review at the offices in Belleville, Illinois, and included the following:

Heather Scalia – Director, Quality and Utilization Management
Beverly Terveer – Quality Improvement Analyst

The interviewees shared information on the validation methods, study design, and findings. Technical assistance regarding study design and presentation of findings was provided by the EQRO. The following questions were addressed:

- Who was the Project Leader?
- How was the topic identified?
- How was the study question determined?
- What were the findings?
- What was the intervention?
- What was the time period of the study?
- Was the intervention effective?
- What does Harmony Health Plan want to study or learn from their PIPs?

The PIPs submitted for validation included a substantive amount of information. Additional analysis has occurred between the time of the original submission of information and the time of the on-site review. The health plan was instructed that they could submit additional information that included enhanced outcomes of the intervention. Additional clarifying written information was received after the on-site review from the health plan.

FINDINGS

The first PIP evaluated was considered non-clinical and was entitled “Medical Record Documentation by Primary Care Physicians (PCPs) and Their Staff/Interventions and Their Efficacy.” The study topic presentation was supported by a literature review and a thorough explanation of the local problem. The topic discussion included results of the health plan’s initial review of PCP medical records, the results, problems identified, and the need for corrective action in this area of service. This PIP was the health plans non-clinical submission. The PIP was related to improved services to members. The stated focus is that good medical records reflect good services to members. The documentation provided supports the stated goal that best practices in record maintenance will improve providers’ ability to serve members’ health care needs.

The primary study question presented was: “Will targeted health plan interventions in education of primary care physicians and their office staff on medical record documentation increase the quality of physicians’ medical record documentation as measured by the WellCare Medical Record Review Tool used on initial Medical Record Review?” A secondary question was also presented: “By educating Primary Care Physicians and their office staff on medical record documentation after receiving less than 80% on a Medical Record Review will Harmony Health Plan of Missouri be able to achieve 90% of all Primary Care Physicians passing a Medical Review Re-audit?” This is clearly a technical and non-clinical study. The study question is complete although with

the introduction of the dual aspects of the two study questions the process is complicated. It does identify the intended resolution or outcome in terms of increasing the overall outcome or results of medical records review.

Indicators are well defined and constructed to provide measures of improvement. The indicators are measures of success. However, the introduction of the second indicator does lead to some confusion. The first indicator is actually a baseline measure: the number of PCPs that pass their initial record review with a score of 80% or greater in comparison to the total number of PCPs that have had a Medical Record Review in the same measurement year. The second indicator is: The percentage of PCPs passing their medical record re-reviews with a score of greater than 90% or more in comparison to the total number of PCPs that have had a Medical Record re-review in the same measurement year. These indicators are attempting to focus on all areas that measure systemic improvements in the medical record review process. The indicators do provide a concrete measurement. The same tool will be utilized for the original measurement and the re-measurement. However, the information presented does lead to some confusion over the difference in comparison percentages and how they relate to one another. The information provided does indicate that the indicators measure a change in the process of care with a strong association on improved outcomes. The project does not exclude any members.

The actual study population is all credentialed network PCPs. The records to be reviewed will come from a random sample based on providers with fifty (50) to one hundred (100) enrolled MO HealthNet members. The method for determining PCPs to be included in the sample was sound and credible. All sampling techniques were detailed including the rationale for the confidence interval utilized.

The data collection and analysis process is provided in specific detail. The data to be collected was defined in the narrative. The health plan included a description of how information is gathered and tracked on their internal system. All the tools used in completing the medical record review, and the health plan's expectations for a complete record are provided. Sources of data are

described and samples are included. The study design specifies the use of clear identification of all data to be collect, the source of date, how baseline data is determined, and how repeat measures will be used that will ensure valid and reliable data. A specific medical record abstraction tool is being used and a sample was available for review. The data collection will occur quarterly, and is analyzed yearly.

In the original submission the PIP documentation did not include a prospective data analysis plan. The enhanced information received after the on-site review did include a detailed analysis plan.

Planned interventions were described in detail in the information provided. The study was initiated in 2007, which provided baseline information and results. Improvement strategies were realistic and appeared to be based on improving identified problem areas. The results though 2007 and planned changes to enhance the study in 2008 were included. The data obtained for the 2007 baseline year were included. The description of the data and the analysis were discussed in a manner that related it to the original data analysis plan. The analysis did identify the initial and repeat measurements. At the time of the evaluation it was not possible to identify real or sustained improvement. It should be noted that the project has real promise for improving PCP functions and therefore positively affecting services to members.

The second PIP evaluated was titled "Lead Screening Performance Improvement." This study was considered clinical and focused on improving the rates of lead screening for young children ages 0 - 2. The project narrative clearly identified how compliance improving the screening process is related to availability of preventive services for members and improved healthcare outcomes. The decision to enact this study was well defined and supported by both state and national data sources. The information presented was based on a substantial literature review that compared both national and regional standards. This review and analysis provided a substantial argument for the topic choice, and also for the interventions identified. The approach to this Performance Improvement Project was not just to present a clinical study, but to implement successful interventions to improve health care service to members with the overarching goal of improving health outcomes for the children affected.

The study question presented was “Will targeted health plan interventions in education of providers in the guidelines of lead screening and testing, and parents of members that are children ages one (1) day to twenty-four (24) months, along with a Paid for Quality Program (PFQ) for Primary Care Physicians increase the number of lead screening in member who are children in the following categories: 1) the first year of life; 2) The second year of life; 3) In the first and second year of life.” The question framed the content and intention of this study. Indicators for this study were included and defined with substantive information about how they were to be counted and analyzed. The indicators did include NCQA quantifiable information. The information provided clearly led the reader to understand that the focus of the study is to improve compliance with recommended lead screening guidelines in an effort to improving health outcomes for children. The population served by this study includes all members’ children in the age range and does not exclude any member with special health care needs.

The data collection methodology was included. Data will be obtained from programmed pulls from claims and encounter files. Data sources were described in detail. These planned pulls are to occur one time per year. The enhanced information provided did attempt to describe a study design with enough detail to ensure that there is confidence in the plan and the process. The additional information does supply information on the data collection process and accurate data collection over time. By limiting the collection and analysis to an annual cycle it will not allow the health plan to make any changes or adjustments throughout the project year that may have a positive impact of expected outcomes.

A prospective data analysis plan was not specifically included, but could be inferred in the additional information received. Additional detail would be helpful in this aspect of the project.

A description of the planned interventions was included for the 2008 project year. The interventions planned are focused on education to providers and their staff, and to parents of members that have not reached their second birthday and are still in need of lead screening. How the various interventions will impact member behavior is not defined. Barriers and other issues that may affect outcomes were not identified or were not included in the information provided.

The desired outcomes and the evaluation process were included. The ultimate goals of the proposed interventions were detailed in the information submitted. The project has not reached a level of maturity that enables any evaluation of its success at this point.

CONCLUSIONS

QUALITY OF CARE

Both PIPs seek to improve the quality of services to members. The non-clinical PIP seeks to improve the how services are recorded for members enabling providers to have accurate and complete medical records for members. The interventions described in the clinical PIP are clearly targeted to improve the quality and effectiveness of preventive services for children improving health care outcomes. By educating providers and members in accessing available and appropriate lead screening services, the health plan will ensure that preventive and the most effective services will be in place.

ACCESS TO CARE

The clinical PIP had a specific focus on access to care. The study sought to ensure that members who were eligible for lead screening received these services in an efficient manner. By undertaking the methodology involved in the Performance Improvement Project the access to care will enhance the members' ability to appropriately utilize these services. The non-clinical PIP also included the theory that improving medical records in an effort to improve information available in members' medical history will improve the care available. The narrative did make the case to ensuring that this goal was addressed through the PIP process. The goals and their relationship to the problems addressed were included in the narrative included.

TIMELINESS OF CARE

The services and interventions used in the clinical PIP did have the specific outcome of improving the timeliness of appropriate preventive services for children. In this PIP the areas of access, quality, and timeliness of care were of the utmost importance. The outcome was focused on improving the availability

and awareness of the need for services so they would be received in a timely manner. The non-clinical PIP considered timeliness in looking at efficient and effective information available for all members. The narrative provided discussed how these new and improved processes would improve timely services to members as the result of the PIP interventions. It should be noted that timely access to care was a stated and implied goal of both projects.

RECOMMENDATIONS

1. Harmony Health Plan has attempted to improve the timeliness, quality, and access to care for members requiring health care services in the process of each of these Performance Improvement Projects. The focus on improving services to members through the PIP process needs to be reflected in the outcome of these studies to ensure that these goals are met in an efficient and effective manner.
2. The health plan should explicitly address how their projects are extended to and pertinent to the entire Region served.
3. The health plan should indicate how these activities will be incorporated into regular agency processes if they indicate success. This is an important aspect of the PIP process and should occur to ensure that improvements continue on a sustained basis.

8.2 Validation of Performance Measures

Harmony Health Plan had not been in operation in Missouri for a long enough period to provide data for the HEDIS 2007 External Quality Review. Therefore, no performance measures were evaluated. However, this plan's performance measure data will be validated and assessed in the 2008 External Quality Review.

8.3 Validation of Encounter Data

FINDINGS

The findings for the encounter data validation are organized according to the encounter data evaluation questions presented in the Technical Methods section for the encounter data validation in the aggregate report. Please refer to the main report for detailed objectives, technical methods and procedures for encounter data validation.

What is the Baseline Level of Completeness, Accuracy, and Reasonableness of the Critical Fields?

For the Medical claim type, there were 1,623 encounter claims paid by the SMA for the period July 1, 2007 through September 30, 2007.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Outpatient Recipient ID field was 100.00% complete, accurate and valid.
3. The Outpatient First Date of Service field was 100.00% complete, accurate and valid.
4. The Outpatient Last Date of Service field was 100.00% complete, accurate and valid.
5. The Outpatient Units of Service field was 100.00% complete, accurate and valid.
6. The Outpatient Procedure Code field 100.00% complete, accurate and valid.
7. The Outpatient Place of Service field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 100.00% complete, accurate and valid.
9. The second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual. Each of these Diagnosis Code fields fell well below the 100% threshold established by the SMA for this validation. The second, third, fourth and fifth Diagnosis Code fields were 51.20%, 28.53%, 19.59%, and 0.00% complete, accurate and valid, respectively. The

remaining fields were blank (incomplete, inaccurate, and invalid).

For the Dental, Home Health, Pharmacy and Inpatient claim types, there were zero (0) encounter claims paid by the SMA for the period July 1, 2007 through September 30, 2007.

For the Outpatient Hospital claim type, there were 6 encounter claims paid by the SMA for the period July 1, 2007 through September 30, 2007. All fields examined were 100.00% complete, accurate, and valid except for the second through fifth Diagnosis Code fields. The second, third, fourth and fifth Diagnosis Code fields fell well below the 100% threshold for completeness, accuracy, and validity established by the SMA (16.67%, 0.00%, 0.00% and 0.00%, respectively). The remaining fields were blank (incomplete, inaccurate, and invalid).

What Types of Encounter Claim Data are Missing and Why?

Based on the above analysis of the accuracy, completeness, and validity of the data in the SMA encounter claims extract file for Harmony Health Plan of Missouri, an error analysis of the invalid entries was conducted for fields which were lower than the 100.00% threshold specified by the SMA. All critical fields were 100.00%.

What is the Level of Volume and Consistency of Services?

When comparing the rate of encounter claim types per 1,000 members, Harmony Health Plan of Missouri demonstrated rates statistically lower than the average for all MO HealthNet Managed Care health plans for all claim types. This was the first year that Harmony participated in the EQR and they had some issues with compatibility between their encounter claims system and that of the SMA.

To examine the degree of match between the SMA encounter claims database and the medical record, 100 encounters from each health plan were randomly selected from all claim types for the period July 1, 2007 through September 30, 2007 for medical record review.

Of the 1,629 encounter claim types in the SMA extract file for July 1, 2007 through September 30, 2007, 100 encounters were randomly selected. Providers were requested to submit medical records for review. There were 91 medical records (91.0%) submitted for review. Encounters for which no documentation was submitted were unable to be validated. The match rate for procedures was 45.0%, with a fault rate of 55.0%. The match rate for diagnoses was 36.0%, with a fault rate of 64.0%.

What Types of Errors Were Noted?

An error analysis of the errors found on the medical record review for procedure and diagnosis was conducted. For the diagnosis code in the medical record, the reasons for diagnosis codes not matching the SMA extract file were missing information (n = 56) and incorrect code found (n=8). For the procedure code in the medical record, the reasons for procedure codes in the SMA extract file not being supported by documentation in the medical record were missing information (n = 30), incorrect code (n=12) and upcoded (3). Examples of missing information included no code; codes listed that were not supported, or codes that did not match the procedure description. Examples of incorrect information included global pregnancy codes billed separately.

To what extent do the MO HealthNet MCHP paid/unpaid encounter claims match the SMA paid database?

Since Harmony Health Plan included internal control numbers that matched those of the SMA, the EQRO conducted the planned analyses comparing MO HealthNet Managed Care health plan encounter data to the SMA encounter claim extract file. The SMA defined “unpaid claims” as those claims that the health plan denied for payment, unpaid claims do not include claims paid via a capitation plan.

For Inpatient Claim Type 0 “paid” encounters 4 “unpaid” claims were submitted. All paid encounter claims matched with the SMA encounter claim extract file. The 4 unpaid claims were not present in the SMA database (as expected); there was a “hit” rate of 100.00% between Harmony encounter claims and the SMA encounter data.

Why are there unmatched claims between the MO HealthNet Managed Care health plan and SMA data files?

The unmatched encounters are due to missing ICN numbers which are required

to match the encounter to that of the SMA. Therefore, in all claim types, the encounter claims were legitimately missing from the SMA extract data.

What are the Data Quality Issues Associated with the Processing of Encounter Data?

While the MO HealthNet Managed Care health plan did submit the data in the requested format (including most ICN numbers), there are a number of ways to improve the data quality by improving the database system. As the Internal Control Number is only assigned by the State database when a claim is paid, it is difficult to match the MO HealthNet Managed Care health plan data of “unpaid” and “denied” claims to the SMA data. As the Internal Control Number is unique only to the encounter, the ICN may be represented in multiple lines of data. To match the MO HealthNet Managed Care health plan data to the SMA data to specific fields, this requires a unique line number. Therefore each service provided within an encounter would have a separate line of data with a unique line identifier.

CONCLUSIONS**STRENGTHS**

1. Encounter data was submitted to the EQRO in the requested format which allowed encounter validation for all claim types.
2. The critical field validation of all claim types submitted resulted in few fields under the SMA established threshold of 100.00% accuracy, completeness, and validity.

AREAS FOR IMPROVEMENT

1. The rate for all six encounter claim types was significantly lower than the average for all MO HealthNet Managed Care health plans.

RECOMMENDATIONS

1. Examine and revise as needed internal system edits for invalid procedure codes in the UB-92 file layout for the Outpatient Procedure Code and Discharge Date fields

2. Run validity checks after the programming of new edits.
3. Continue to work with the SMA to resolve the compatibility issues between the Encounter claims system so that the MCHP can submit and be paid for all member encounters.

8.4 MO HealthNet MCHP Compliance with Managed Care Regulations

METHODS

Harmony Health Plan of Missouri is in its second year of operation as a MO HealthNet Managed Care health plan. It began operations in the State of Missouri, upon receiving a contract with the MO HealthNet Division (MHD) on July 1, 2006. A full compliance audit was not conducted on Harmony Health Care in 2006. During 2007 the health plan did submit policy and procedures for review by the State Medicaid Agency (SMA). Prior to the site visit, documentation was received and reviewed regarding the health plan's compliance with the State contract. The External Quality Review Organization (EQRO) reviewed contract documents with the staff of the MHD. On-site review time was used to conduct interviews with those who oversee the daily activities of the health plan to ensure that the practices that are in place are within the scope of the contract and are conducted in a manner that meets or exceeds federal regulations.

A detailed protocol (BHC MO HealthNet Managed Care Health Plan Compliance Review Scoring Form) was utilized to review policy compliance by the health plan. Additional document review occurred prior to the on-site review. The health plan also assisted by providing additional documents for review after the date of the on-site review.

On-site review time was used to conduct interviews with Member Services' Staff and Supervisors, and separately with Case Management Staff and Supervisors. This approach was utilized to validate the practices occurring when serving members. These interactions and responses were compared to policy requirements to ensure that both are within the scope of the contract and are conducted in a manner that meets or exceeds federal regulations.

A detailed interview tool, individualized for Member Services' Staff and for Case

Management staff, was utilized to ensure that all pertinent elements of the federal regulations were addressed in the interview process. Additionally, an individualized interview tool was constructed for administrative staff to validate and clarify these practices and to follow-up on questions raised from the interviews.

Additional document reviews occurred after the on-site review to validate any policies and procedures that were in question after discussions with the SMA, and after the review of the health plans annual report.

DOCUMENT REVIEW

The Division of Medical Services supplied:

- State of Missouri Contract Compliance Tool (including MHD responses and comments)

The following documents were requested for on-site review:

- Member Handbook
- Provider Handbook
- 2006 Marketing Plan and Materials
- Policy Tracking Log
- Staff Training Log
- Credentialing Policies and Audit Reports
- Grievance Logs (Member and Providers)

Additional documentation made available by Harmony Health Plan included:

- Marketing Plan and Educational Material Development Policy
- 2006 Marketing Materials
- Harmony Care Organizational Chart
- Quality Improvement Program Description 2007-2008
- Harmony Health Plan of Missouri Program Description Binder

INTERVIEWS

Interviews were conducted on-site at Harmony Health Plan's Belleville, Illinois offices on July 19, 2007 with the following groups:

Plan Administration

- Heather Scalia – Director, Utilization Management and Quality Improvement
- Carol Ouimet – Manager, Regulatory Affairs
- Beverly Terveer – QI Analyst
- Teresa Soria – Social Service Specialist
- Dr. Tammaji Kulkarni – Medical Director
- Tina Gallagher – Executive Director
- Steve Aguirre – Director, Operations
- Maresa Corder – Senior Director, Disease and Case Management
- Brian Gibson – Manager, Case Management
- Brenda Bryant – Senior Provider Relations Representative
- Carmella Hardnet – Manager, Community Relations and Marketing
- Bill Gaither – Document Control Specialist
- Jason Bollent – Sr. Manager, Medicaid Customer Services

Member Services Staff

- Steve Aguirre – Director, Operations
- Kendra Graham (T) – Member Services Representative
- Bill Gaither – Document Control Specialist
- Carol Ouimet – Manager, Regulatory Affairs
- Jason Bollent (T) – Sr. Manager, Medicaid Customer Services
- Cary Izquierda – Customer Services Staff
- Grise Gallegas – Customer Services Staff

Case Management Staff

- Brian Gibson – Manager, Case Management
- Kevin Cassidy (T) – Case Manager

- Robin Clark (T) – Case Manager
- Carolyn Mather (T) – Case Manager
- Jeff McCann (T) – Case Manager
- Leslie Reseman (T) – Case Manager
- Doug Quinto (T) – Case Manager
- Heather Scalia – Director, Utilization Management and Quality Improvement

FINDINGS

ENROLLEE RIGHTS AND PROTECTIONS

Harmony Health Plan of Missouri is a part of WellCare Health Plans, Inc., due to a corporate merger that occurred in 2004. Harmony has been providing Medicaid Managed Care Services in states other than Missouri for a number of years. The behavioral health organization providing services through August 2007 was Psych Health, a subcontractor. The health plan reported that another WellCare subsidiary, Harmony Mental Health, assumed responsibility for providing behavioral health services on September 1, 2007.

The health plan reported having approximately 11,000 members at the time of the on-site review. The predominant population is pregnant women, according to Harmony data. The majority of members resided in St. Louis City and County, but their member population was slowly expanding to the adjoining counties. The health plan has a goal of upgrading their service delivery system and ensuring that staff and programs provide quality care for their current members. The health plan reports that they are aware of the need to have culturally diverse staff and providers. They are contracted with Language Access Metro Project (LAMP) for interpreter services. They are able to translate written materials as needed.

Harmony does have an active Obstetrics Program for pregnant women. They send out OB notification forms, conduct direct member outreach, and complete

a thorough needs assessment. Home visits occur for members identified as high risk. The health plan reports that it makes an immediate referral for behavioral health services when a need is assessed, and also makes referrals for postpartum support. The Harmony network does include Peoples Clinic and Grace Hill, two St. Louis Federally Qualified Health Centers (FQHCs). The health plan regards their relationship with the FQHCs as vital to ensuring adequate access to care for members. The provider representatives conduct monthly visits to the FQHCs to maintain this resource.

The health plan medical director, Dr. Tammaji Kulkarni, MD, gave a presentation regarding the health plan's goals and philosophy. He shared that the health plan strives to promote a culture of compliance. It is the health plan's goal to improve community partnerships, to enhance staff engagement and to lay a ground work for future growth. They seek to serve their current members successfully, while achieving targeted growth in enrollment. The health plan seeks to maintain a multi-disciplinary approach to oversight and quality improvement activities. They seek to continue to improve communication with members and providers.

The health plan operates a Customer Service/Quality Improvement Group, which reviews grievances and appeals, enrollment issues, and authorizations. All of these committees report to the Harmony Quality Committee for Missouri and Illinois. The health plan has also embarked on community outreach. They are involved with the Boys and Girls Clubs in the Western Region, and operate a birthday club for children in their membership.

The health plan has customer service staff that is assigned to their Missouri population based in Chicago, Illinois. They have back-up staff available from the Illinois and Kentucky programs, which have been trained on the MO HealthNet Managed Care program. Harmony nursing staff, as well as their Pharmacy Director, has met with physicians in Missouri. During these visits they promoted the EPSDT program and encouraged the completion of screenings, and assessments to assist in the identification of members with special health care needs.

The case management team is located at the health care facility in Tampa, Florida. Case management includes lead, special health care needs, and intensive case management. Members receive case management at their request or if referred by a provider, hospital staff, or from the information listing received from the SMA.

Member Services staff related that calls received in their department were usually for PCP changes. They search on-line for providers who may be near the member's location. They utilize the member's area code and provide names of PCPs that are nearest their location.

Case Managers report that their section, utilization management and disease management are provided from the Tampa, Florida offices. Disease management is available for diabetes, CHF, and asthma. These services are supported by a fully integrated data program for sharing information between case managers, disease management staff, medical staff, pharmacy and behavioral health staff. The interactive communication system provides a preliminary screen for case managers or disease managers, and contains real-time information to the users. Referrals to the case management program come from a variety of sources including physician referrals, data mining through claims and prenatal reports, the Missouri enrollment broker, daily hospital census, Member Services, and self referrals. Special needs cases are identified through claims for durable medical equipment, pharmacy, and diagnosis codes. The health plan also operates an outreach program for pregnant members. Clinical assessments are completed using the health plan's information system with a guide that triggers questions, includes behavioral health needs, and a stratification that sets a level of need for follow-up.

The rating for Enrollee Rights and Protections (69.2%), reflects a lack of complete and approved policy and procedures. It is to be noted that this is the health plan's first full compliance review. They have submitted policy to the SMA and are working to complete the approval process required. They had not established tracking and internal processes at the time of the on-site review. Harmony Health Plan exhibited a businesslike approach and commitment to continue their efforts to improve in the completion and submission of required policies and procedures that will comply with the MO HealthNet Managed Care

contract. They have a stated goal of partnering the State agency (MHD) to ensure compliance in this and all areas of policy development.

Table 61 – Subpart C: Enrollee Rights and Protections Yearly Comparison (Harmony Health Plan)

Federal Regulation	Harmony	
		2007
438.100(a) Enrollee Rights: General Rule		2
438.10(b) Enrollee Rights: Information Requirements		2
438.10(c)(3) Alternative Language: Prevalent Language		2
438.10(c)(4,5) Language and Format: Interpreter Services		2
438.10(d)(1)(i) Information Requirements: Format/Easily Understood		2
438.10(d)(1)(ii) and (2) Information Requirements: Format Visually Impaired, and Limited Reading Proficiency		2
438.10(f) Information for All Enrollees: Free Choice, etc.		1
438.10 (g) Information to Enrollees: Specifics/Physician Incentive Plans		2
438.10(i) Special Rules: Liability for Payment/Cost Sharing		2
438.100(b)(2)(iii) Enrollee Rights: Provider-Enrollee Communications		0
438.100(b)(2)(iv,v) Rights to Refuse Services/Advance Directives		1
438.100(b)(3) Right to Services		1
438.100(d) Compliance with Other Federal/State Laws		2
Number Met		9
Number Partially Met		3
Number Not Met		1
Rate Met		69.2%

Note: 0 = Not Met; 1= Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

Access Standards

Harmony Health Plan of Missouri continues to make an effort to improve in the area of access standards. The health plan has submitted policies and procedures to the SMA for annual review as required. They are actively working to increase their provider panel throughout the Eastern Region. Additional work with providers includes educating them regarding the HEDIS measures, and emergency room utilization. The health plan marketing department is continuing with network development and report that this has been challenging. They have struggled in engaging physicians in the counties outside of St. Louis,

but are still competitive there. The SSM Health Care system has contracted with the health plan.

Member Services staff report that when a member reports difficulty in obtaining access to their PCP, their medical records, or in obtaining an appointment, they contact the PCP office and intervene on the member's behalf. When members call and report that they have difficulty obtaining services after-hours or on weekends, the member is provided with information on accessing urgent care centers and the nurse-advice line. Member Service staff try to resolve the problem and document information, which is then forwarded to the Provider Services and/or Grievance Departments. Member Services staff report that if they receive a call for emergency services, that they "assist as needed" and arrange transportation as required.

Case Managers relate that they do assist members in obtaining appointments and locating the health care services they require. They also discussed how they handle situations when a member reports receiving an adverse action decision to an authorization. The Case Manager explains member benefits, and assists the member in contacting the Appeals Department. The case manager remains on the telephone with the member and provides advocacy and assists as needed.

Ratings for compliance with Access Standards (52.9%) reflect the efforts by the health plan to submit complete required policy to meet the requirements of the MO HealthNet Managed Care contract and federal regulations. This is the first year that all required policy and procedure are completed and submitted for the approval process. Harmony Health Plan voiced their willingness to continue their efforts to develop necessary policy and practice to be in full compliance and to obtain full compliance. Observations made at the time of the on-site review indicated that these efforts were continuing and full compliance was an ongoing health plan goal.



Table 62 – Subpart D: Quality Assessment and Performance Improvement: Access Standards Yearly Comparison (Harmony Health Plan)

Federal Regulation	Harmony	
		2007
438.206(b)(1)(i-v) Availability of Services: Provider Network		1
438.206 (b) (2) Access to Well Woman Care: Direct Access		1
438.206(b)(3) Second Opinions		2
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage		2
438.206(b)(5) Out of Network Services: Cost Sharing		2
438.206(c)(1)(i-vi) Timely Access		2
438.206(c)(2) Provider Services: Cultural Competency		2
438.208(b) Care Coordination: Primary Care		1
438.208(c)(1) Care Coordination: Identification		1
438.208(c)(2) Care Coordination: Assessment		1
438.208(c)(3) Care Coordination: Treatment Plans		1
438.208(c)(4) Care Coordination: Direct Access to Specialists		1
438.210(b) Authorization of Services		1
438.210(c) Notice of Adverse Action		2
438.210(d) Timeframes for Decisions, Expedited Authorizations		2
438.210(e) Compensation of Utilization Management Activities		2
438.114 Emergency and Post-Stabilization Services		2
Number Met		9
Number Partially Met		8
Number Not Met		0
Rate Met		52.9%

Note: 0 = Not Met; 1= Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols.

Structures and Operation Standards

Harmony Health Plan of Missouri continues to develop their credentialing standards. The health plan assured the EQR that all providers maintained licensure and the right to practice in Missouri. The health plan developed a work plan to ensure that the remaining provider list would be current during the coming year. The health plan reported that they are current on all providers due for credentialing. Delegated credentialing is utilized but Harmony provides strict

oversight of these functions.

The health plan operates a dedicated quality improvement program that utilizes an active Medical Advisory Committee. They also operate physician outreach and education programs to enhance their ability to communicate and support providers. This includes one-on-one physician education sessions, as well as group training sessions. They utilize provider newsletters and other outreach activities to provide information and feedback to the provider network.

Harmony Health Plan has also developed a “Pay for Quality (PFQ) Program” for providers. This program is measured by NCQA/HEDIS standards.

Member Services staff report a sound knowledge of the policies and procedures to utilize if a health plan member calls and requests disenrollment. They do ask questions to reason with members and to identify the type of problem and if a resolution is possible. The staff relate that they often find that the genesis of the call is dissatisfaction with a provider. When they can assist with the problem they often find that the resolution creates an environment where the member no longer wishes to pursue disenrollment. If a member persists in their wish to disenroll, the member services staff assists them through this process.

Care Managers related that they were not directly involved in this aspect of health plan operations.

The rating for Structure and Operation Standards (70%) reflects the efforts the health plan has made for their first submission of policy to the SMA for their review and approval. It appears that all required policy has been submitted but is in the revision and approval process. The health plan understood that continued efforts in this area of practice will be needed. Observations at the time of the on-site review support that Harmony Health Plan of Missouri has a commitment to completing and improving areas that may be viewed as problematic.

Table 63 – Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison (Harmony Health Plan)

Federal Regulation	Harmony	
		2007
438.214(a,b) Provider Selection: Credentialing/Recredentialing		1
438.214(c) and 438.12 Provider Selection: Nondiscrimination		1
438.214(d) Provider Selection: Excluded Providers		2
438.214(e) Provider Selection: State Requirements		2
438.226 and 438.56(b)(1-3) Disenrollment: Requirements and limitations		2
438.56(c) Disenrollment Requested by the Enrollee		2
438.56(d) Disenrollment: Procedures		2
438.56(e) Disenrollment: Timeframes		2
438.228 Grievance System		1
438.230(a,b) Subcontractual Relationships and Delegation		2
Number Met		7
Number Partially Met		3
Number Not Met		0
Rate Met		70%

Note: 0 = Not Met; 1= Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols.

Measurement and Improvement

Harmony Health Plan has developed and implemented specific practice guidelines with providers at the time of the 2007 review. The health plan has now instituted the National Heart, Lung, and Blood Guidelines for asthma care for adults and children. This information and the methods to utilize these guidelines have been distributed to all health plan providers.

Harmony Health Plan has instituted a number of Quality Assessment and Performance Improvement activities during 2007. Their Quality Improvement group meets regularly and includes local physicians who actively participate. The health plan's goal of providing quality services to members was the focus of

the group's discussions. The Quality Improvement section is an active and essential section of health plan operations. The health plan plans to use the quality improvement process to ensure that all members have adequate access to services, timely and appropriate services, and also to improve relationships and support of providers.

Case Managers and Member Services Staff report that they have not been asked by members for access to information, such as practice guidelines. Both groups knew that this information was available and could be accessed for members if needed.

Harmony Health Plan did submit two well-constructed Performance Improvement Projects (PIPs) for validation. Although these PIPs lacked complete maturity to allow for validation, they indicated that the health plan does utilize this process as a tool for health plan growth. The structure of both PIPs followed the federal protocol and showed a great deal of potential. These PIPs indicated an understanding of the importance of the PIP process in improving health plan operations and health care services to members.

The health plan was not required to submit information for Validation of Performance Measures as they will not be required to complete HEDIS documentation until the 2008 service year. Harmony Health Plan continued to operate a health information system within the guidelines of that protocol. All encounter data requested was provided in the correct format. The complete details of each of these areas of validation can be reviewed within specific sections of this report.

The rating for Measurement and Improvement (36.4%) reflects the fact that this is the initial submission of policy and procedures for the health plan. The health plan is actively engaged in the revision and approval process with the SMA.

Table 64 – Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement Yearly Comparison (Harmony Health Plan)

Federal Regulation	Harmony	
		2007
438.236(b)(1-4) Practice Guidelines: Adoption		2
438.236(c) Practice Guidelines: Dissemination		2
438.236(d) Practice Guidelines: Application		2
438.240(a)(1) QAPI: General Rules		1
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCO Quality Improvement and PIPs		1
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement		2
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization		1
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs		1
438.240(e) QAPI: Program Review by State		NA
438.242(a) Health Information Systems		1
438.242(b)(1,2) Health Information Systems: Basic Elements		1
438.242(b)(3) Health Information Systems: Basic Elements		1
Number Met		4
Number Partially Met		7
Number Not Met		0
Rate Met		36.4%

Note: Regulation 438.240(e) refers to program review by the state. The regulation requires the state to review, at least annually, the impact and effectiveness of each MCHP's quality assessment and performance improvement program. The regulation refers to the state QA & I program review process and is not applicable to External Quality Review of the MC+ Managed Care Program. This percent is calculated for the regulations that are applicable to the MC+ Managed Care Program. 0 = Not Met; 1 = Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols.

Grievance Systems

Information regarding a member's grievance is recorded and forward to the Grievance Department in Tampa, Florida. Member Service staff relate the information contained in the Member Handbook to the member and assist as needed with filing a written grievance. If a member calls with an issue that appears to be a grievance, but they do not wish to file a grievance, the staff relates that they will record the information shared, and forward it to the Grievance Department, with a note that the member did not request further

action.

Written information from members regarding grievances and appeals are received by fax, mail and e-mail. The information is logged in the health plan's information system, the member is contacted to obtain clarifications and additional information, and an acknowledgement letter is sent to the member. If a provider is involved the Provider Relations office is notified. If the issue is actually an appeal, the information is then forward to the Appeals Department. Grievances are also referred to the Corporate Service Escalation Unit, which works with dissatisfied customers. WellCare has separated their units into Medicaid and Medicare specialties. This unit attempts to resolve member issues or assist the member in understanding the outcome of the process.

Case Management staff relate that they most often become involved is a member receives an adverse reply to a request for authorization. The Case Manager explains the member benefits, and assists the member in contacting the Appeals Department. The Case Managers feel that they remain involved if possible acting as a member advocate through both the grievance and appeals processes.

The rating for the Grievance System (5.6%) reflects a lack of approval of the majority of policy and procedures required to meet MO HealthNet Managed Care contract requirements and federal policy. Practices observed at the time of the on-site review indicated that Harmony Health Plan has a sound understanding regarding operation of a grievance and appeals system. However, policy submission, revision and approval are not yet complete.

Table 65 – Subpart F: Grievance Systems Yearly Comparison (Harmony Health Plan)

Federal Regulation	Harmony	
		2007
438.402(a) Grievance and Appeals: General Requirements		1
438.402(b)(1) Grievance System: Filing Requirements - Authority		1
438.402(b)(2) Grievance System: Filing Requirements - Timing		1
438.402(b)(3) Grievance System: Filing Requirements - Procedures		1
438.404(a) Grievance System: Notice of Action - Language and Format		1
438.404(b) Notice of Action: Content		1
438.404(c) Notice of Action: Timing		1
438.406(a) Handling of Grievances and Appeals: General Requirements		1
438.406(b) Handling of Grievance and Appeals: Special Requirements for Appeals		1
438.408(a) Resolution and Notification: Basic Rule		1
438.408(b,c) Resolution and Notification: Grievances and Appeals - Timeframes and Extensions		1
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice		1
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings		2
438.410 Expedited Resolution of Appeals		1
438.414 Information about the Grievance System to Providers and Subcontractors		1
438.416 Recordkeeping and Reporting Requirements		1
438.420 Continuation of Benefits while Appeal/Fair Hearing Pends		1
438.424 Effectuation of Reversed Appeal Resolutions		1
Number Met		1
Number Partially Met		17
Number Not Met		0
Rate Met		5.6%

Note: 0 = Not Met; 1= Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols

CONCLUSIONS

Harmony Health Plan is a small but emerging MO HealthNet Managed Care health plan operating in the Eastern Region. The staff is able to articulate their health plan goals and the requirements for service delivery associated with the SMA contract and the federal guidelines. Through involvement in other Medicaid Managed Care markets, the health plan is familiar with the requirements in meeting all written policies and procedures. They are struggling in submitting policy that is specific to this contract and that satisfies the SMA in meeting all requirements of writing policy and procedures.

QUALITY OF CARE

The Harmony staff is keenly aware of their responsibility to ensure adequate access to quality healthcare in a timely manner. They realize that obtaining full compliance is an essential component in the compliance process. The health plan's efforts and commitment to provide quality services to members was apparent in meeting with administrative staff, and in interviewing Member Services and Case Management staff during the on-site review. The health plan needs to continue to strive to meet all the SMA requirements. They voiced their awareness that creating an environment where all member services meet their quality standards is an evolving process, but are able to voice their sincere commitment to achieving their goals.

ACCESS TO CARE

Harmony Health Plan has improved their provider network and continues to fully develop service delivery in their region. The health plan has not met policy and procedure requirements in this area of operation. The Member Services and Case Management staff express an understanding of the importance of access to care for members. However, there is some disconnect noted in responses that reflected a lack of integration between departments within the health plan: this may lead to members experiencing a less coordinated or collaborative approach to problem solving.



TIMELINESS OF CARE

Harmony Health Plan is aware of the importance of timeliness in the provision of health care to members. This is an area where complete and approved policy is the foundation for ensuring that members receive services in a timely fashion, have a timely response to questions, and a timely turnaround on issues such as grievances and appeals. Harmony Health Plan has strong goals, supported by health plan leadership, and communicated throughout the organization, to meet all of the requirements for policy development and implementation. These goals should allow the health plan to become fully compliant in this area, and ensure timely delivery of health care services to members.

RECOMMENDATIONS

1. Continue to develop the atmosphere within Harmony Health Plan that motivates the attention to compliance with contractual requirements and federal regulations.
2. Develop communication that enables front line staff to have a coordinated and collaborative work environment that supports adequate information sharing.
3. Continue to utilize the resources at Harmony Health Plan to complete all necessary policy documentation and submission to the SMA.
4. Continue to enhance quality improvement initiatives internally within the organization to ensure that quality services occur for members.
5. Continue to support front line staff in their efforts to be primary advocates for members and to provide an atmosphere based on the desire to provide excellent healthcare services to members.
6. Continue to utilize available data and member information in order to drive, change, and measure performance.
7. Complete and submit all required policy for approval to the SMA in a timely manner.
8. Continue efforts in the areas of network development and community

relation building.

9. Provide oversight to the transition of behavioral health services to a new provider to ensure that members maintain provider relationships, and continue to receive the services required.

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9.0 HealthCare USA

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9.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

HealthCare USA supplied the following documentation for review:

- Performance Improvement Project 2007: Appeals and Grievances
- Performance Improvement Project 2007: Improving Post-Discharge Management of Members Discharged from an Inpatient Service for Mental Illness

INTERVIEWS

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on July 9, 2008 during the on-site review at offices in St. Louis, and included the following:

Jackie Inglis – VP, Health Services
Kate Darst – Director, Quality Improvement
Debbie Fitzgerald -- Director, Health Services
Rick Littell – VP of Operations, MHNet
Sheryl Jeffries – VP Quality Improvement, MHNet

The interviewees shared information on the validation methods, study design, and findings. Technical assistance regarding study design and presentation of findings was provided by the EQRO. The following questions were addressed:

- Who was the Project Leader?
- How was the topic identified?
- How was the study question determined?
- What were the findings?
- What was the intervention?
- What was the time period of the study?
- Was the intervention effective?
- What does HCUSA want to study or learn from their PIPs?



The PIPs submitted for validation included a substantive amount of information. Additional analysis has occurred between the time of the original submission of information and the time of the on-site review. The health plan was instructed that they could submit additional information following the on-site review that included enhanced outcomes of the intervention. Additional clarifying written information was received after the on-site review from HealthCare USA and MHNNet.

FINDINGS

The first PIP evaluated was considered non-clinical and was entitled “Appeals and Grievances.” The study topic presentation explained the attempted literature review and the research completed in justifying the decision for topic selection. The narrative included information from the State and local levels that provided support for topic choice. The choice actually focused on improving systemic and policy issues relevant to both members and providers. The topic narrative implied a goal of ensuring that member needs are met and that answers are delivered to members and providers in a timely and effective manner. However, the stated topic only discusses reducing the number of complaints, grievances and appeals. More explicit discussion of this goal would improve the validity of this non-clinical focus and clarify the actual foundation for the study topic.

The study question presented was: “Will identifying and resolving the most frequent reasons for: member grievances and appeals; and provider complaints, grievances, and appeals, decrease the overall rates and result in improved timeliness and an overall decrease in the overturn rate?” This is clearly a technical and non-clinical study. The study question is complete. It does identify the intended resolution or outcome in terms of reducing the number of grievances and appeals. It does not provide which parameters the health plan

is to meet to be successful.

Indicators are well defined and constructed to provide measures of improvement. The list of indicators is comprehensive. These indicators focus on all areas that measure systemic improvements and also on the specific areas that provide information on measuring complaints, grievances and appeals. The indicators do measure the number of complaints grievances and appeals, but also examine the reasons for them in an effort to improve services to members and providers. The project is designed to include all member grievance and appeals, and all provider complaints, grievances and appeals with no exclusions. The data collection plan outlined ensured the inclusion of all appropriate information.

The data collection and analysis process is provided in specific detail. The data to be collected was defined in the narrative. The health plan included a description of how information is gathered and tracked on their internal grievance and appeal system. Information is provided through the Navigator software system and Access databases. The data was categorized according to the interventions. The timeliness and outcomes of each complaint, grievance, and appeal was also tracked in the Access system. The health plan staff extracted data and the PIP included very specific definitions about the analysis of the data and the manner in which they intended to evaluate the data. The study included a systematic method for ensuring that valid and reliable data will be collected. This methodology included an explanation of capturing all complaints, grievances and appeals, as well as the reason, timeliness, and outcome for both members and providers. CAHPS and Provider Surveys will also be utilized to assess the reasons the complaints, grievances and appeals. The study included a detailed prospective data analysis plan. The work group members and their roles in performing the data analysis were described in detail. The processes and methodology to be used was also described.

Planned interventions were described in detail in the information provided. The study was initiated in 2006. The results and planned changes to enhance the study in 2007 were included. The data gathered for both 2006 and 2007 was included. The description of the data and the analysis were not discussed in a manner that related it to the original data analysis plan. The analysis did identify the initial and repeat measurements. References to barrier analysis indicated that more information might be available. The information provided remained vague and did not specifically relate these comments to the complaints, grievances, and appeals. The initial results appeared positive. Changes and enhancements initiated throughout 2006 and 2007 were included. These changes were implemented to perfect the structure of the project and improve outcomes. In the original information provided all of these changes were not directly related to the stated interventions, leading to some confusion in relating the outcomes to the original interventions. In updates received after the on-site review, additional information was provided allowing a more complete evaluation of the outcomes information, thereby allowing evaluators to relate the interventions to the reported conclusions. The support of this project, evidenced by the participation of a multidisciplinary team within the health plan, displays a commitment to address member and provider issues. The detail that can be surmised from the graphs and accompanying information does indicate promising results for organizational corrective action.

The second PIP evaluated was titled “Improving Post-Discharge Management of Members Discharged from an Inpatient Service for Mental Illness.” This study was considered clinical and focused on improving compliance with ambulatory follow-up appointments after discharge from inpatient mental health treatment, as an important factor in preventing re-hospitalizations. The project narrative clearly identified how compliance with improved aftercare treatment is tied to access and availability of services for members. The decision to enact this study

was well defined and supported by both local data and information and based on a substantial literature review that compared both national and regional standards. This review and analysis provided a substantial argument for the topic choice, and also for the interventions identified. The approach to this Performance Improvement Project was not just to present a clinical study, but to implement successful interventions to improve services to members. This study was focused all three regions.

The current study question presented was “Whether more adherence to aftercare and discharge planning to include education for families and members increases compliance for post-hospitalization referral visit within seven (7) or thirty (30) days.” The question framed the content and intention of this study. Indicators for this study were included and defined with substantive information about how they were to be counted and analyzed. The indicators did include NCQA quantifiable information. The information provided clearly led the reader to understand that the focus of the study is to improve compliance with recommended aftercare services thereby improving outcomes regarding prevention of subsequent in-patient treatment. The population served by this study includes all three regions. It does include all members who begin this intervention prior to discharge from an inpatient level of care.

The data collection methodology was included. Data was obtained quarterly and put in reports. These reports were then combined and analyzed on a yearly basis. Data sources and how they were to be measured and utilized in impacting services to members, and how they would be used to analyze project success were provided. A complete prospective data analysis plan was not specifically included. The information providing the history of this quality initiative and updates that led to the current study was available and the aspects of a prospective plan were woven throughout the documentation. Adequate information was available to ensure that data analysis planning occurred. A

stand alone prospective data analysis plan was mentioned. The information provided ensured that consistent and accurate data collection would occur.

An analysis of the findings was included from the 2003 baseline information and the 2004-2007 re-measurement data. All interventions and new procedures, specific to the 2007 project were supplied in detail. Barriers and other issues were identified. The current project did analyze the data within the confines of the study design. Repeated measurements and comparisons were presented. It does appear that improvements that are identified are the results of the planned interventions. The outcomes were discussed in detail in the Qualitative Analysis section of each measure reviewed by interventions. This narrative provided some history of what type of interventions lacked success, leading to the current interventions, which did show quantitative success. Arguments were presented that the changes implemented as the result of this project created or sustained the improvements noted. It does appear that this project has had a significant positive impact on member behavior. The outcomes presented, which identify the importance of the case management process in understanding member behavior and barriers, thus allowing improved interventions, such as in-home therapy, directly led to statistically significant project success.

At the time of the on-site review additional information and clarification were made available. All information presented was well documented, labeled and explained. The data does indicate real improvement. Over time the outcomes of this PIP indicate that the interventions did increase the use of follow-up services in both 7 and 30 days. The utilization of these services decreased the need for in-patient treatment. The results also indicate that services available to members also improved. Case management services assisted in ensuring that members were aware of available services and had the supports needed to utilize these services.

CONCLUSIONS

QUALITY OF CARE

Both PIPs seek to improve the quality of services to members. The non-clinical PIP seeks to improve the issues that lead to complaints, grievances and appeals for members and providers. In terms of internal procedures and practices this PIP could have the effect of improving services that will decrease the incidence of complaints, grievances, and appeals. If the health plan engages in appropriate follow-up it will identify members who remain in need of health care services, or will be able to provide a more adequate explanation of the denial of services. The interventions described in the clinical PIP are clearly targeted to improve the quality and effectiveness of aftercare services for members receiving inpatient mental health treatment. By assisting members in accessing outpatient treatment services, and thereby avoiding the need for repeat inpatient treatment, the MO HealthNet Managed Care health plan will ensure that both preventive services and the most effective services will be in place.

ACCESS TO CARE

The clinical PIP had a specific focus on access to care. The study sought to ensure that members who had received in-patient treatment for mental health related issues were aware of the need to begin and continue to access outpatient treatment services. By undertaking the methodology involved in the Performance Improvement Project the access to outpatient care improved, as did the members who appropriately utilized these services. The non-clinical PIP also included the theory of improving services in an effort to reduce the numbers of grievances and appeals. The narrative did make the case to ensuring that this goal was addressed through the PIP process. The goals and their relationship to the problems addressed were included in the narrative included. The PIPs and the supporting documentation indicating how these projects would improve

access to services were evident throughout the project.



TIMELINESS OF CARE

The services and interventions used in the clinical PIP did have the specific outcome of improving the timeliness of appropriate outpatient services for any member who had received in-patient mental health services. In this PIP the areas of access, quality, and timeliness of care were of the utmost importance. The outcome was focused on improving the availability of services at seven and thirty days following inpatient services. Timely access to care was a main focus of this project and the interventions utilized had the effect of improving the number of members who attended outpatient treatment in the required timeframes. The non-clinical PIP considered timeliness in looking at the resolution of the grievance and appeal processes. The narrative provided discussed how these new and improved processes would improve timely services to members as the result of the PIP interventions. It should be noted that timely access to care was a stated and implied goal of both projects.

RECOMMENDATIONS

1. HealthCare USA has attempted to improve the timeliness, quality, and access to care for members requiring health care services in the process of each of these Performance Improvement Projects. The non-clinical project information provided a stated goal that was specific and articulated as improving services and benefits to members. The non-clinical PIP did include a prospective data analysis plan in the project planning documentation submitted after the time of the on-site review. The format of all PIPs should contain complete narrative information on all aspects of the project to ensure that the project is understandable and complete.
2. The health plan should explicitly address how their projects are extended to and pertinent to all the Regions served. In making the improvements experienced in the Eastern Region available to the Central and Western

Regions some alterations may be required to replicate the effectiveness of the interventions.

3. The health plan indicated that the processes described in both PIPs are to be incorporated in the regular agency processes. This is an important aspect of the PIP process and should occur to ensure that improvements continue on a sustained basis.

9.2 Validation of Performance Measures

METHODS

This section describes the documents, data, and persons interviewed for the Validating Performance Measures Protocol for HealthCare USA. HealthCare USA submitted the requested documents on January 28, 2008. The EQRO reviewed documentation between January 28, 2008 and July 1, 2008. On-site review time was used to conduct follow-up questions and provide feedback and recommendations regarding the performance measure rate calculation.

DOCUMENT REVIEW

The following are the documents reviewed by the EQRO:

- The HealthCare USA Baseline Assessment Tool (BAT) for the HEDIS 2007 data reporting year
- HealthcareData.com LLC's Compliance Audit Report for HEDIS 2007
- HealthCare USA's information systems policies and procedures with regard to calculation of HEDIS 2007 rates
- HealthCare USA meeting minutes on information system (IS) policies
- A sample of Catalyst's production logs and run controls
- National Council on Quality Assurance (NCQA)-certified HEDIS software certification report from Catalyst Technologies
- Data field definitions & claims file requirements of the Coventry Corporate Data Warehouse

- Data files from the Coventry Corporate Data Warehouse containing the eligible population, numerators and denominators for each of the three measures.
- HEDIS 2007 Data Submission Tool
- HEDIS 2007 product work plan

The following are the data files submitted by HealthCare USA for review by the EQRO:

- DenominatorData_ADV.txt
- EnrollmentData_ADV.txt
- DenominatorData_AWC.txt
- EnrollmentData_AWC.txt
- DenominatorData_FUH.txt
- EnrollmentData_FUH.txt

INTERVIEWS

The EQRO conducted on-site interviews at HealthCare USA in St. Louis on Wednesday, July 9, 2008 with Kate Darst, Quality Manager and Laura Fraser, Q.I. Coordinator. Also available by phone were Rena David-Clayton and Geoff Welsh, who represented the software vendor Catalyst Technologies. This group was responsible for calculating the HEDIS 2007 performance measures. The objective of the visit was to verify the methods and processes behind the calculation of the three HEDIS 2007 performance measures.

FINDINGS

HealthCare USA calculated all three of the HEDIS 2007 measure being reviewed using the Administrative method. MO HealthNet Managed Care health plan to MO HealthNet Managed Care health plan comparisons of the rates of Annual Dental Visit, Adolescent Well-Care Visits, and Follow-Up After Hospitalization measures were conducted using two-tailed z-tests. For comparisons that were statistically significant at the 95% confidence interval (CI), the z-score (z), the upper and lower confidence intervals (CI), and the significance levels ($p < .05$) are reported.

The reported Adolescent Well-Care Visit rate was 36.37%; this is comparable to the statewide rate for all MO HealthNet Managed Care health plans (34.81%; $z = -0.33$, 95% CI: 28.89%, 40.74%; n.s.). This reported rate is lower than the rate (39.31%) reported by the health plan during the 2004 EQR review.

The Follow-Up After Hospitalization for Mental Illness measure is reported in both 7 day follow-up and 30 day follow-up rates. HealthCare USA reported a 7 day rate of 27.35%, which is significantly lower than the statewide rate for all MO HealthNet Managed Care health plans (35.52%; $z = -0.34$, 95% CI: 22.96%, 48.08%; $p < .05$). This 7 day rate is lower than the rate (29.04%) reported by the health plan during the 2006 report. The 30 day rate of 50.58% reported by HealthCare USA was comparable to the statewide rate for all MO HealthNet Managed Care health plans (60.06%; $z = 1.38$, 95% CI: 47.50%, 72.62%; n.s.). However, this rate is also lower than the rate (51.03%) reported by the health plan during the 2006 report.

The combined rate for the HEDIS 2007 Annual Dental Visit measure reported by HealthCare USA to the SMA and the State Public Health Agency (SPHA) was 32.23%. This was comparable to the statewide rate for all MO HealthNet Managed Care health plans (32.50%, $z = 0.04$; 95% CI: 29.30%, 35.69%; n.s.). This rate is higher than the rate (29.04%) reported by the health plan during the 2005 report.

The following sections summarize the findings of the process for validating each of the performance measures in accordance with the Validating Performance Measures Protocol. The findings from all review activities are presented according to the EQRO validation activity, with the findings for each measure discussed within the activities as appropriate. Please refer to the tables in the main report for activities, ratings, and comments related to the CMS Protocol Attachments.

DATA INTEGRATION AND CONTROL

The information systems management policies and procedures for rate calculation were evaluated consistent with the Validating Performance

Measures Protocol. This included both manual and automatic processes of information collection, storing, analyzing and reporting. For all three measures, HealthCare USA was found to meet all the criteria for producing complete and accurate data (see Attachment V: Data Integration and Control Findings). There were no biases or errors found in the manner in which HealthCare USA transferred data into the repository used for calculating the HEDIS 2007 measures. HealthCare USA used an NCQA-certified software vendor, Catalyst, for the HEDIS 2007 measure calculation process.

DOCUMENTATION OF DATA AND PROCESSES

Although Healthcare USA uses a proprietary software package to calculate HEDIS measure rates, adequate documentation of this software and its processes was provided to the EQRO for review. The data and processes used for the calculation of measures were adequate (see Attachment VII: Data and Processes Used to Calculate and Report Performance Measures). HealthCare USA met all criteria that applied for all three measures.

PROCESSES USED TO PRODUCE DENOMINATORS

HealthCare USA met all criteria for the processes employed to produce the denominators of the performance measures validated (see Attachment X: Denominator Validation Findings). This involves the selection of eligible members for the services being measured. Denominators in the final data files were consistent with those reported on the DST for the three measures validated. All members were unique and the dates of birth ranges were valid.

A total of 33,762 eligible members were reported for the Adolescent Well-Care Visits measure.

A total of 775 eligible members were reported for the denominator of the Follow-Up After Hospitalization measure.

There were 88,406 eligible members reported and validated for the denominator of the Annual Dental Visit measure.

PROCESSES USED TO PRODUCE NUMERATORS

All three measures were calculated using the Administrative Method. Measures included the appropriate data ranges for the qualifying events (e.g., well-child visits, follow-up visits, or dental visits) as specified by the HEDIS 2007 Technical Specifications (see Attachment XIII: Numerator Validation Findings). No medical record reviews were conducted or validated.

For the HEDIS 2007 Adolescent Well-Care Visits measure, there were a total of 12,279 administrative hits reported and 12,382 hits found. This resulted in a validated rate of 36.67%; with a reported rate of 36.37%, this is an underestimate of 0.31%.

The number of administrative hits reported for the HEDIS 2007 Follow-Up After Hospitalization for Mental Illness measure (7 day rate) was 212; the EQRO found 210. This resulted in a reported rate of 27.35% and a validated rate of 27.10%: an overestimate of 0.26%. The EQRO verified 389 of 392 hits for the 30 day rate, resulting in a reported rate of 50.58% and a validated rate of 50.19%. This is a 0.39% overestimate by the health plan for this measure.

HealthCare USA reported a total of 28,493 administrative hits for the Annual Dental Visit measure; 28,447 of these hits were validated by the EQRO. This resulted in a reported rate of 32.23% and a validated rate of 32.18%, an overestimate of 0.05%.

SAMPLING PROCEDURES FOR HYBRID METHODS

No medical record reviews were conducted or validated. CMS Protocol Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings do not apply to the Administrative Method.

SUBMISSION OF MEASURES TO THE STATE

HealthCare USA submitted the DST for each of the three measures to the SPHA (the Missouri Department of Health and Senior Services) in accordance with the Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) and the SMA Quality Improvement Strategy.

DETERMINATION OF VALIDATION FINDINGS AND CALCULATION OF BIAS

As previously noted, the health plan overestimated both the Follow-Up After Hospitalization for Mental Illness and Annual Dental Visit measures. The Adolescent Well-Care Visits measure was underestimated.



Table 66 - Estimate of Bias in Reporting of HCUSA HEDIS 2007 Measures

Measure	Estimate of Bias	Direction of Estimate
Adolescent Well-Care Visits	0.31%	Underestimate
Follow- Up After Hospitalization (7 days)	0.26%	Overestimate
Follow-Up After Hospitalization (30 days)	0.39%	Overestimate
Annual Dental Visit	0.05%	Overestimate

FINAL AUDIT RATING

The Final Audit Rating for each of the performance measures was based on the findings from all data sources that were summarized in the Final Performance Measure Validation Worksheet for each measure. The rates for the Follow-Up After Hospitalization for Mental Illness and Annual Dental Visit measures were overestimated, and the Adolescent Well-Care Visits measure was underestimated, but all fell within the confidence intervals reported by the health plan.

Table 67 - Final Audit Rating for HCUSA Performance Measures

Measure	Final Audit Rating
Adolescent Well-Care Visits	Substantially Compliant
Follow- Up After Hospitalization (7 days)	Substantially Compliant
Follow-Up After Hospitalization (30 days)	Substantially Compliant
Annual Dental Visit	Substantially Compliant

Note: Fully Compliant = Measure was fully compliant with State specifications; Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate; A significant bias in the rate was defined as a number calculated by the EQRO that fell outside the 95% confidence interval of the rate reported by the health plan. Not Valid = Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported; Not Applicable = No MO HealthNet Managed Care Members qualified for the measure.

CONCLUSIONS

All but one of the four of the health plan's performance measure reported rates were consistent with the average for all MO HealthNet Managed Care health plans; the remaining rate was lower than the average.

QUALITY OF CARE

HealthCare USA's calculation of the HEDIS 2007 Follow-Up After Hospitalization for Mental Illness measure was substantially compliant with specifications. This measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care delivered. HCUSA's 30-day rate for this measure was consistent with the average for all MO HealthNet Managed Care health plans; the 7-day rate was significantly lower than the average rate. Both of these rates were also lower than the rates reported by the health plan during the 2006 report. However, HCUSA's members are receiving the quality of care for this measure consistent with the care delivered to all other MO HealthNet Managed Care members within the 30-day timeframe, but are receiving a lower quality of care in the 7-day timeframe.

The EQRO was able to validate this rate within the reported 95% confidence interval and thereby has confidence in the calculated rate.

ACCESS TO CARE

The Annual Dental Visit measure was substantially compliant with specifications; this measure is categorized as an Effectiveness of Care measure. Because only one visit is required for a positive "hit", this measure effectively demonstrates the level of access to care that members are receiving. Healthcare USA's rate for this measure was consistent with the average for all MO HealthNet Managed Care health plans. This rate was higher than the rate reported by the health plan during the 2005 report, thereby showing that HCUSA members are receiving

more dental services than during the 2005 HEDIS reporting year. HCUSA's members are receiving the quality of care for this measure consistent with the care delivered to all other MO HealthNet Managed Care members.



The EQRO was able to validate this rate within the reported 95% confidence interval and thereby has confidence in the calculated rate.

TIMELINESS OF CARE

The health plan's calculation of the HEDIS 2007 Adolescent Well-Care Visits measure was substantially compliant. This measure is categorized as a Use of Services measure and is designed to measure access to and timeliness of the care defined. The health plan's reported rate for this measure was consistent with the average for all MO HealthNet Managed Care health plans, however the rate reported was less than the rate reported for the same measure during the 2004 report. HCUSA's members are receiving the timeliness of care for this measure consistent with the care delivered to all other MO HealthNet Managed Care members.

The EQRO was able to validate this rate within the reported 95% confidence intervals and thereby has confidence in the calculated rate.

RECOMMENDATIONS

1. The health plan's 7-day rate for Follow-up After Hospitalization for Mental Illness was significantly lower than the average rate for all MO HealthNet Managed Care health plans. This rate was also lower than the rate reported by the health plan in 2005. The EQRO recommends the health plan concentrate efforts to improve this rate.
2. The health plan should consider the use of medical record review (when allowed by HEDIS specifications) as a way to improve reported rates.
3. Work to increase rates for all measures; although most measures were consistent with the average for all MO HealthNet Managed Care health plans, they were well below the National Medicaid averages and most

were lower than the rates reported by the health plan during prior EQR years.

9.3 Validation of Encounter Data

FINDINGS

The findings for the encounter data validation are organized according to the encounter data evaluation questions presented in the Technical Methods section for the encounter data validation in the aggregate report. Please refer to the main report for detailed objectives, technical methods and procedures for encounter data validation.

What is the Baseline Level of Completeness, Accuracy, and Reasonableness of the Critical Fields?

For the Medical claim type, there were 567,007 encounter claims paid by the SMA for the period July 1, 2007 through September 30, 2007.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Outpatient Recipient ID field was 100.00% complete, accurate and valid.
3. The Outpatient First Date of Service field was 100.00% complete and accurate, and valid.
4. The Outpatient Last Date of Service field was 100.00% complete and accurate, and valid.
5. The Outpatient Units of Service field was 100.00% complete, accurate and valid.
6. The Outpatient Procedure Code field was 100.00% complete and accurate, and 99.99% valid. The following are the three invalid entries found:

Code	# of times
99261	4
99262	1

7. The Outpatient Place of Service field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 100.0% complete, accurate valid.

9. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, the second, third, fourth, and fifth Diagnosis Code fields fell well below the 100.00% threshold set by the SMA for completeness, accuracy and validity. The Diagnosis Code fields were 15.06%, 6.76%, 5.99%, and 0.00% complete, accurate and valid respectively. All the remaining fields were blank (incomplete, inaccurate, and invalid).

For the Dental claim type, there were 73,646 encounter claims paid by the SMA for the period July 1, 2007 through September 30, 2007. All fields examined were 100.00% complete, accurate and valid.

For the Home Health claim type, there were four (4) encounter claims paid by the SMA for the period July 1, 2007 through September 1, 2007. All fields examined were 100.00% complete, accurate and valid.

For the Inpatient claim type, there were 64,598 encounter claims paid by the SMA for the period July 1, 2007 through September 1, 2007.

1. The Inpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Recipient ID field was 100.00% complete, accurate and valid.
3. The Admission Type field was 100.00% complete, accurate and valid.
4. The Admission Date field was 100.00% complete and accurate, and valid.
The Discharge Date field was 100.00% complete with the correct number of characters (size). The correct type of information (date format) was present 98.28% (with 1,109 entries of "99999999"); thereby the Discharge Date field was 98.28% accurate and valid.
5. The Bill Type field was 100.00% complete, accurate and valid.
6. The Patient Status field was 100.00% complete and accurate, and valid.
7. The first Diagnosis Code field was 100.0% complete, accurate and valid.
8. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, the second, third, fourth, and fifth Diagnosis Code fields fell below the 100% threshold for completeness, accuracy, and validity established by the SMA (99.99%, 99.98%, 90.40%, and 73.38%, respectively).
9. The First Date of Service field was 100.00% complete and accurate, and valid.
10. The Last Date of Service field was 100.00% complete and accurate, and valid.
11. The Revenue Code field was 99.92% complete, accurate, and valid. There

were 49 invalid blank fields.

12. The Units of Service field was 100.00% complete, accurate and valid.

For the Outpatient Hospital claim type, there were 244,711 encounter claims paid by the SMA for the period July 1, 2007 through September 30, 2007.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Recipient ID field was 100.00% complete, accurate and valid.
3. The First Date of Service field was 100.00% complete, accurate and valid.
4. The Last Date of Service field was 100.00% complete, accurate and valid.
5. The Units of Service field was 100.00% complete, accurate and valid.
6. The Outpatient Procedure Code field was 100.00% complete, accurate, and 39.29% valid. There were 148,572 invalid entries of "00000", 263 invalid entries of "00915", 1 entry of "00901", and 2 entries of "00913".
7. The first Diagnosis Code field was 100.00% complete, accurate and valid.
8. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, the second, third, fourth, and fifth Diagnosis Code fields fell below the 100% threshold for completeness, accuracy, and validity established by the SMA (99.99%, 99.99%, 53.0%, and 26.09%, respectively).

For the Pharmacy claim type, there were 285,221 claims paid by the SMA for the period July 1, 2007 through September 30, 2007. All fields examined were 100.00% complete, accurate and valid.

What Types of Encounter Claim Data are Missing and Why?

Based on the above analysis of the accuracy, completeness, and validity of the data in the SMA encounter claims extract file for HealthCare USA, an error analysis of the invalid entries was conducted for fields which were lower than the 100.00% threshold specified by the SMA. There were very few errors encountered in the critical fields examined across all claim types. The Inpatient claim type contained invalid data in the Discharge Date fields. The Revenue Code field contained blank entries. For the Outpatient Hospital claim type, the Outpatient

Procedure Code fields contained invalid entries.



What is the Level of Volume and Consistency of Services?

When comparing the rate of encounter claim types per 1,000 members, the rate of Medical Encounter claims was significantly higher than the average for all MO HealthNet Managed Care health plans. All other encounter claim types were consistent with the average for all MO HealthNet Managed Care health plans. This suggests average rates of encounter data submission and good access to preventive and acute care. This could also be a function of the fact that HCUSA has the greatest number of encounter claims processed for all plans and thereby the outliers (if there are any) are not as prominent.

To What Extent do the Claims in the State Encounter Claims Database Reflect the Information Documented in the Medical Record? What is the Fault/Match Rate between State Encounter Claims and Medical Records?

To examine the degree of match between the SMA encounter claims database and the medical record, 100 encounters from each MO HealthNet Managed Care health plan were randomly selected from all claim types for the period of July 1, 2007 through September 30, 2007 for medical record review.

Of the 1,235,187 encounter claim types in the SMA extract file for July 1, 2007 through September 30, 2007, 100 encounters were randomly selected. Providers were requested to submit medical records for review. There were 93 medical records (93%) submitted for review. Encounters for which no documentation was submitted were unable to be validated. The match rate for procedures was 52.0%, with a fault rate of 48.0%. The match rate for diagnoses was 39.0%, with a fault rate of 61.0%.

What Types of Errors Were Noted?

An error analysis of the errors found on the medical record review for procedure, diagnosis, name of drug dispensed, and quantity of drug dispensed was

conducted. For the diagnosis code in the medical record, the reasons for diagnosis codes not matching the SMA extract file were missing information (n = 54) and incorrect (n=7).

For the procedure code in the medical record, the reasons for procedure codes in the SMA extract file not being supported by documentation in the medical record were missing information (n = 39), incorrect (n=8) and upcoded (n=1). Examples of missing information included no code; codes listed that were not supported, or codes that did not match the procedure description.

To what extent do the MO HealthNet MCHP paid/unpaid encounter claims match the SMA paid database?

Since HealthCare USA included internal control numbers that matched those of the SMA, the planned analysis of comparing MO HealthNet Managed Care health plan encounter data to the SMA encounter claim extract file was performed. The SMA defined “unpaid claims” as those claims that the health plan denied for payment, unpaid claims do not include claims paid via a capitation plan.

For the Pharmacy Claim type, all encounter data submitted to the EQRO was of “paid” status. For the Dental Claim type, all encounter data submitted to the EQRO was of “paid” status. For both claim types, there were no unmatched claims that were in the HCUSA encounter file and absent from the SMA data. Thus, 100.00% of the HCUSA submitted encounters matched with the SMA encounter records.

For the Outpatient Medical Claim Type (n= 567,007), 41 “denied” claims were submitted by HCUSA but all other encounter claims were of “paid” status. For the Outpatient Hospital Claim Type (n = 244,711), 13 “denied” claims were submitted by HCUSA but all other encounter claims were of “paid” status. Of the encounter claims submitted by HCUSA, 54 records were unmatched with the SMA encounter data. There was a “hit” rate of 99.99% between HCUSA encounter claims and the SMA encounter data.

For the Inpatient Claim Type, HCUSA submitted 64,598 encounter claims. Only 32 of these encounter claims were of “denied” status; all other claims were of “paid” status. There were 00 unmatched records between HCUSA and the SMA, yielding a 99.99% “hit” rate.

Why are there unmatched claims between the MO HealthNet Managed Care health plan and SMA data files?

For all claim types, the unmatched encounters were missing ICN numbers which are required to match the encounter to that of the SMA. Therefore, there were no documented “missing” claims from the SMA database.

What are the Data Quality Issues Associated with the Processing of Encounter Data?

While the MO HealthNet Managed Care health plan did submit the data in the requested format (including most ICN numbers), there are a number of ways to improve the data quality by improving the database system. As the Internal Control Number is only assigned by the State database when a claim is paid, it is difficult to match the MO HealthNet Managed Care health plan data of “unpaid” and “denied” claims to the SMA data. As the Internal Control Number is unique only to the encounter, the ICN may be represented in multiple lines of data. To match the MO HealthNet Managed Care health plan data to the SMA data to specific fields, this requires a unique line number. Therefore each service provided within an encounter would have a separate line of data with a unique line identifier.

CONCLUSIONS

STRENGTHS

1. All encounter data was submitted in the specified format and included internal control numbers (ICNs) which allowed the EQRO to conduct planned comparisons of the MO HealthNet Managed Care health plan and SMA data files.
2. The critical field validation of all six claim types resulted in few fields under the SMA established threshold of 100.00% accuracy, completeness, and validity.
3. The critical fields examined for the Dental and Pharmacy claim types were 100.00% complete, accurate and valid.

AREAS FOR IMPROVEMENT

1. For the Medical claim type, there were invalid entries for the Procedure Code fields.
2. For the Inpatient claim type, there were invalid entries for the Discharge Date fields.
3. For the Outpatient Hospital claim type, there were invalid data in the Outpatient Procedure Code field.
4. The health plan had a significantly lower rate of Encounter Data Diagnosis Validation than all MO HealthNet Managed Care health plans.

RECOMMENDATIONS

1. Examine and revise as needed internal system edits for invalid procedure codes in the NSF/CMS 1500 file layout for the Outpatient Procedure Code and run validity checks after the programming of new edits.
2. Ensure that Admission Date, Discharge Date, and Diagnosis fields are complete and valid for the Inpatient (UB-92) claim types, and institute error checks to identify invalid data.



9.4 MO HealthNet MCHP Compliance with Managed Care Regulations

METHODS

Prior to the site visit, documentation was received and reviewed regarding the MO HealthNet Managed Care health plan compliance with the State contract. The External Quality Review Organization (EQRO) reviewed contract documents with the staff of the MO HealthNet Division (MHD). On-site review time was used to conduct interviews with those who oversee the daily practices of the health plan. This ensures that documentation is developed and practices occur within the scope of the contract and in a manner that meets or exceeds federal regulations.

A detailed protocol (BHC MO HealthNet Managed Care Health Plan Compliance Review Scoring Form) was utilized to ensure that all the elements of the federal regulations were addressed in the review process. Additionally, an interview tool was constructed to validate practices that occur at the health plan and to follow-up on questions raised from the document review and from the 2006 External Quality Review. Document reviews occurred on-site to validate that practices and procedures were in place to guide organizational performance.

On-site review time was used to conduct interviews with Member Services' Staff and Supervisors and separately with Case Management Staff and Supervisors. This approach was utilized to validate the practices occurring when serving members. These interactions and responses were compared to policy requirements to ensure that both are within the scope of the contract and are conducted in a manner that meets or exceeds federal regulations.

A detailed interview tool, individualized for Member Services' Staff and for Case Management staff, was utilized to ensure that all pertinent elements of the federal regulations were addressed in the interview process. Additionally, an interview tool was constructed for administrative staff to validate and clarify these practices and to follow-up on questions raised from the interviews.

DOCUMENT REVIEW

The Division of Medical Services supplied:

- State of Missouri Contract Compliance Tool (including DMHN responses and comments)

The following documents were requested for on-site review:

- Member Handbook
- Provider Handbook
- 2007 Marketing Plan and Materials
- Policy Tracking Log
- Grievance Logs (Members and Providers)
- 2007 Annual Quality Improvement Program Evaluation
- Care Management: Case Management, Complex Case Management, and Disease Management Policy
- Algorithms for Case Management, Disease Management, and Pregnancy Case Management
- Lead Case Management Policy
- Assessment of Members with Special Health Care Needs policy
- Case Management/Concurrent Review Policy

Additional documentation made available by HealthCare USA included:

- HCUSA of Missouri Organizational Chart
- Beary Important Bundle HCUSA's Guide for High Risk Pregnancy

- Beary Important Bundle HCUSA's Guide for Pregnancy
- Mental Health Network, Inc – 2007 Quality Improvement Work Plan

INTERVIEWS

Interviews were conducted with the following groups:

Plan Administration

- Jackie Inglis, VP Health Services
- Nancy Marshall, MD, Medical Director
- Carl Bynum, DO, Medical Director
- Kate Darst, Director of Quality Improvement
- Resmi Jacob-Schrieber, Director of Provider Relations
- Gene Poisson, Director of Network Development
- Deb Fitzgerald, Director of Health Services

Member Services Staff

- Claudia Huffman, Compliance
- Paula DiSabatina, Manager, Member Services
- Tina Dabler, Member Services Staff
- Theresa Campbell – Member Services Staff

Case Management Staff

- Sharon McDonald, RN
- Tasha Sharp, RN
- Stephanie Wise, RN
- Deidre Gyebi, RN
- Valerie Waller, RN
- Janet Wilson, RN
- Mandy Kennedy, Social Worker

Grievance and Appeals Unit

- Maureen Kaelin, Compliance Analyst
- Bonnie Kirchhoff, Compliance Analyst

- Jennifer Clark, Compliance Analyst



FINDINGS

ENROLLEE RIGHTS AND PROTECTIONS

A strong commitment to member rights continues to be a cornerstone of HealthCare USA's service philosophy. The emphasis placed on continuous quality improvement by the health plan was apparent in both the documentation reviewed and throughout staff interviews. Quality services to members, with a particular emphasis on families and children, were observed within the organization. HealthCare USA views cultural diversity as an essential component of their interactions with members. The health plan maintains cultural diversity as a cornerstone of initial and ongoing staff training. HealthCare USA employed staff that speak different languages and are able to provide written materials in languages other than English. Maintaining the ability to serve a culturally diverse population with a variety of special service needs is exhibited in the health plan's approach to their work and to their interactions with members.

HealthCare USA has expanded their ability to communicate with visually and reading impaired members by contracting to produce their member handbook and other materials in Braille and on CD. They have information translated into other languages as well.

The health plan has continued efforts to impact members experiencing high risk pregnancies or with a history of premature birth. HealthCare USA reports that their members are producing 850 births per month. A percentage of these babies go to the neonatal intensive care unit (NICU), and a percentage experience congenital birth defects. The MCHP is making every attempt to identify women at risk by using the Global Risk Assessment scale at the onset of pregnancy. However, this was not identifying problems that some women experienced later during pregnancy. They have piloted a project whereby providers send in postcards to the health plan if they identify a situation change

for a pregnant woman that increases her risk for problems or premature birth. Cards are also requested from physicians who have a teen patient that becomes pregnant. High risk pregnancies receive the most intensive level of case management. They are now beginning to do data analysis, including outcome and process measures, for these members. The Medical Director completes “rounds” regularly with these case managers. They visit high volume providers and also send a special OB newsletter to providers. This is assisting the health plan in finding at-risk members and measuring the effectiveness of their interventions.

HealthCare USA is making efforts to leverage community relations in all three Regions. They work with the FQHCs in these regions and have developed a number of special projects. The health plan is working with LINC in the Western Region, which is the local community partnership group, and the Spanish Center to ensure that they are addressing the needs that might be peculiar to the Kansas City population. They are working with community groups in the Central Region to address issues specific to the rural population. One example is that HealthCare USA providers are conducting dental screens at community based activities.

Beginning in September 2007, the MCHP began to utilize students from the Chamberlain School of Nursing and Community Health. They hope to enhance these individual's case management skills, while expanding the capacity of the health plan in providing expanded case management services.

As a follow-up on their asthma initiatives, the health plan provided information on a project that is occurring in all three Regions. The health plan monitors member adherence to physician visits and medication. When a member does visit their physician or pharmacy, they are asked to verify all contact information and future commitment to keeping appointments. After attending so many appointments, they receive a gift card, with information on "Kids' Health" aimed at parents, teens, and younger children. Another initiative that the health plan started, in an effort to obtain current contact information for members, is placing a message on new membership cards asking that the member call the toll free number. Members view this as "activating" their card, even though the card is active as soon as it is issued. Not only have members receiving the message complied, but other health plan members have called in because they have seen this request on the cards of friends or neighbors. This has greatly enhanced the health plan's ability to have correct contact information for members at a minimal expense.



HealthCare USA was asked about their EPSDT program as a follow-up from the prior year's review. The update provided information that members in all three Regions receive reminders and post cards. The health plan staff conducts record reviews. Coventry, the health plan's parent company, has developed reminder letters that are generated automatically to ensure that appointment reminders are sent to members on a regular basis.

The health plan has developed and is utilizing a Member Advisory Committee in all three Regions.

Interviews with Member Services staff reveal that they receive a six to eight week training regimen to prepare them to respond to questions and issues regarding the MO HealthNet Managed Care contract, fraud and abuse, member rights and responsibilities, and HIPPA. The Member Services call center is located in Connecticut. The staff was present in St. Louis for the on-site review. They reported that they have been in the area before, but learn from being in the area and become familiar with the neighborhoods that health plan members speak of during calls. The Member Services staff was astute in recognizing members' needs and issues. They gave examples of the calls received and responses they provide. There was a high degree of cooperation and collaboration with these staff members. They discussed an Enrollee Rights Audit that occurred in early 2007, completed by mock interviews with other Customer Representatives. The audits revealed a need for additional education. Member Services now assure that member informational materials are current and distributed to members in a timely manner. They have had training on understanding the member's cultural perspective regarding health care needs. Other aspects of the enhanced training include team building, and an awareness of signs of fraud and abuse.

Case Managers and the social worker in their department also exhibited a strong

sense of collaboration and coordination. They also discussed that this collaborative effort includes the MHNet case manager, with whom they exchange information freely. The social worker provides a linkage with community based agencies that can provide that will assist the members with services that may exceed their health care needs.

Case Managers receive referrals from an array of sources including the Member Services staff, PCPs, specialists, members, health risk assessments, MHNet, the transportation staff, local and State health departments, from internal reports, from the website, and hospitals. Case managers do in-depth assessments with members after a receipt of a new referral. This includes a disease assessment and a more general assessment process. This information is reviewed and updated with members every ninety days. All members with a special health care need also have a written treatment plans. These are completed in coordination with the member's physician. The member has access to the treatment plan and will receive a copy if requested.

The case managers make special efforts to make frequent telephone contacts with their members. They have been trained in patient-centered interviewing. The health plan is continuing to investigate how to evolve the case management process to become interactive rather than reactive. The health plan is attempting to create an atmosphere that supports members, while focusing on member responsibility and independence.

The health plan does have case management staff located in all Regions. They utilize the Health Risk Assessment received through the SMA as much as possible. The health plan reports that community connections, particularly in the rural areas, and provider referrals are more effective in identifying members with special health care needs.

Ratings of compliance with Enrollee Rights and Protections (100%) indicate that HealthCare USA made a concerted effort to improve their compliance in this area. The health plan completed all required policies and these were approved by the SMA. Interviews with administrative, Member Services and Case Management staff indicated a commitment to attend to the details of completing required policies and maintaining this level of success, and further to

ensure that these policies are operationalized in interactions with health plan members. The health plan had a stated goal of 100% compliance with SMA contract requirements and federal regulations, which was achieved for the second year.

Table 68 – Subpart C: Enrollee Rights and Protections Yearly Comparison (HCUSA)

Federal Regulation	HealthCare USA		
	2005	2006	2006
438.100(a) Enrollee Rights: General Rule	2	2	2
438.10(b) Enrollee Rights: Information Requirements	1	2	2
438.10(c)(3) Alternative Language: Prevalent Language	2	2	2
438.10(c)(4,5) Language and Format: Interpreter Services	1	2	2
438.10(d)(1)(i) Information Requirements: Format/Easily Understood	2	2	2
438.10(d)(1)(ii) and (2) Information Requirements: Format Visually Impaired, and Limited Reading Proficiency	2	2	2
438.10(f) Information for All Enrollees: Free Choice, etc.	1	2	2
438.10 (g) Information to Enrollees: Specifics/Physician Incentive Plans	2	2	2
438.10(i) Special Rules: Liability for Payment/Cost Sharing	1	2	2
438.100(b)(2)(iii) Enrollee Rights: Provider-Enrollee Communications	2	2	2
438.100(b)(2)(iv,v) Rights to Refuse Services/Advance Directives	2	2	2
438.100(b)(3) Right to Services	2	2	2
438.100(d) Compliance with Other Federal/State Laws	2	2	2
Number Met	9	13	13
Number Partially Met	4	0	0
Number Not Met	0	0	0
Rate Met	69.2%	100.0%	100.0%

Note: 0 = Not Met; 1 = Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols.

BEHAVIORAL HEALTH

Individuals from the behavioral health subcontractor, MHNet, were interviewed at the on-site review. The MHNet staff shared information regarding a number of initiatives undertaken during 2007. One project involved the support of members through targeted follow-up when they are discharged from inpatient treatment. Another measure focused on avoiding weekend discharges for members requiring inpatient treatment. MHNet's goal was to have the member ready for discharge prior to Saturday to avoid weekend emergencies.

The Behavioral Health Organization's (BHO) system was undergoing enhancement to capture baseline information on members receiving behavioral health services. MHNNet continues the practice of authorizing family therapy, in addition to required individual therapy, for all children under age 21 who need behavioral health services. The BHO believes that this additional resource will assist in ensuring that the family had an understanding of issues facing their child, that the entire family would be working together to ameliorate problems, and that the family would understand the child's emotional functioning. The BHO works closely with HealthCare USA to identify expectant mothers to ensure that required behavioral health services were in place in an effort to prevent post partum problems. The BHO has also made a concerted effort to ensure that information and educational material is translated into different languages. Multilingual providers are available to members.

The health plan in collaboration with MHNNet has made a concerted effort to offer adequate case management services between the two agencies. They provide case management to any member requiring a hospital admission, who attempts suicide, during and immediately after pregnancy, who has a history of non-compliance, and/or those with serious disease management issues. Case managers maintain regular phone contacts to ensure coordinated and necessary services and supports, such as transportation, are in place. The BHO relates that they are making an effort to keep primary care physicians informed. The feedback they have received is that the PCPs are surprised and appreciate these coordination efforts.

MHNNet has developed a number of other tools to support the members they serve. These include: a guide for parents who have children with autism; a program for treatment of obesity; targeted services for children diagnosed with Attention Deficit Hyperactivity Disorder; and a newsletter with information for pregnant and post partum members. The BHO recognizes that differences exist

in the three Regions and has worked with the respective Community Mental Health Clinics and C-STAR programs to develop strong working relationships. These groups are invited to meetings every two to three months to discuss current issues, meet staff, and to develop strong organizational relationships.



QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

Access Standards

HealthCare USA worked with both members and providers to ensure proper access to services was available. They developed a large provider network throughout all three Regions, and continued to recruit providers to expand services available, particularly in the Central Missouri area. This enabled members to have an adequate choice for both PCPs and specialty providers. The MCHP does authorize the use of out-of-network providers when this will best meet a member's healthcare needs.

One of the health plan's efforts during 2006 and 2007 was to recruit dental providers. They have had some success, but relate that this is an ongoing initiative. They made an effort to work with providers who were not traditionally MO HealthNet Managed Care vendors. With receipt of appropriate medical background information, these providers have accepted health plan members. The dental subcontractor, Doral Dental, placed a provider representative in the Central Region to ensure ample recruitment occurred and that a representative was available locally to assist in problem solving when this was required. Doral Dental initiated a work plan to obtain additional providers. HealthCare USA Provider Relations worked with Doral to ensure that the subcontractor had assistance as needed. Special attention was given to the issue of transportation while this network development continues. The health plan paid for mileage when a member had a vehicle, or another method of transportation to attend dental appointments, when they occurred at an excessive distance. This assisted in increasing the availability of services. Another method utilized by the health plan was negotiating an alternative fee schedule for providers reluctant to participate due to reimbursement issues. HealthCare USA reported that the network did improve, but they continue to concentrate on development efforts.

The health plan continues its efforts to monitor their provider network for accessibility and availability of both primary care physicians and specialists in all

three Regions. The health plan makes an effort on behalf of members to share information about changes in provider availability, and to provide assistance in making appointments or identifying an appropriate provider if necessary. This activity was reported by both the Member Services staff and the Case managers interviewed. The health plan is also participating in member events, such as Back to School Fairs, to provide information about the availability and accessibility of services. In the Western Region, the FQHC, Swope Health Services, is providing school physicals, dental screenings, and vision screenings for children. HIV screenings and mammograms are provided for adults. The screenings coordinated with Swope Health Services are available to all children, whether or not they are health plan members. If a child is not a HealthCare USA member pertinent information is forwarded to the appropriate MO HealthNet Managed Care health plan. Several smaller fairs and events occurred in the Central Region. One of these events is scheduled for Boone and one in Callaway Counties. Additionally the health plan will be involved in 38 other events in the Central Region. In the Eastern Region the health plan is scheduled to participate with over fifty vendors in North St. Louis City and South St. Louis County.

The health plan participates in baby showers that are held at the FQHCs in all Regions. Babies 'R Us was included in the Western Region to provide seminars and informational information to parents. These occurred at the Sam Rogers and Swope Health Services clinics.

Member Service staff could relate examples of issue that arise regarding members' access to care. They also discussed situations when members call to request disenrollment. They discussed the request with members to determine if the member understands their health plan benefits, and to discern if they actually need help with a provider, or if they are having a problem with a provider. They relate that occasionally members call because another family

member is enrolled in a different health plan, or are having a provider issue. In some instances, Member Services staff relates that they are able to find a provider who is more acceptable to a member, or can assist in resolving other issues. When this occurs the member sometimes rescinds their request to disenroll. In other instances they process the request and ensure that the correct unit receives the request and all necessary information to process the request.

Case Managers discussed their efforts to ensure that members obtain timely and appropriate services. They directly contact PCPs and specialists if barriers exist to obtaining appointments or other necessary services. Case Managers also discussed members' rights to refuse case management services. When this occurs the case managers attempt to educate members on other community services available, and educate about how to work with their providers. The case manager then sends a post card with their name and a message that they can be available again if the member has future service needs.

Ratings of compliance with Access Standards regulations (100%) for the second year, and reflect the fact that all HealthCare USA policies have been submitted, reviewed, and approved by the SMA. The health plan has improved in this area each year, and continues to strive to meet all required SMA contract requirements and federal regulations.

Table 69 – Subpart D: Quality Assessment and Performance Improvement: Access Standards Yearly Comparison (HCUSA)

Federal Regulation	HealthCare USA		
	2005	2006	2006
438.206(b)(1)(i-v) Availability of Services: Provider Network	2	2	2
438.206 (b) (2) Access to Well Woman Care: Direct Access	2	2	2
438.206(b)(3) Second Opinions	2	2	2
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	2	2	2
438.206(b)(5) Out of Network Services: Cost Sharing	1	2	2
438.206(c)(1)(i-vi) Timely Access	1	2	2
438.206(c)(2) Provider Services: Cultural Competency	2	2	2

438.208(b) Care Coordination: Primary Care	2	2	2
438.208(c)(1) Care Coordination: Identification	1	2	2
438.208(c)(2) Care Coordination: Assessment	2	2	2
438.208(c)(3) Care Coordination: Treatment Plans	1	2	2
438.208(c)(4) Care Coordination: Direct Access to Specialists	2	2	2
438.210(b) Authorization of Services	2	2	2
438.210(c) Notice of Adverse Action	1	1	2
438.210(d) Timeframes for Decisions, Expedited Authorizations	2	2	2
438.210(e) Compensation of Utilization Management Activities	2	2	2
438.114 Emergency and Post-Stabilization Services	1	2	2
Number Met	11	17	17
Number Partially Met	6	0	2
Number Not Met	0	0	0
Rate Met	64.7%	100.0%	100.0%

Note: 0 = Not Met; 1= Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols.

Structures and Operation Standards

HealthCare USA instituted a number of measures to improve practice in this area in 2005 that continued during 2006 and 2007. The health plan holds quarterly oversight meetings with all subcontractors in each region to discuss service provision issues and to monitor activities. The meetings are used to monitor key performance indicators and to review provider panels. Annual evaluations are completed on each subcontractor, and daily contact is maintained.

HealthCare USA reported this increased contact and monitoring allowed them to address administrative and member issues in a timely and effective manner.

On-site reviews were also conducted by the health plan during 2007 to assess the providers' use of practice guidelines, and to review that all required documentation was in place. This has been effective in ensuring the quality and timely provision of care.

HealthCare USA created a provider advisory group, which is currently functioning in the Eastern Region and is becoming operational in all three Regions. The committee is made of high volume providers and representatives from across specialties. The sharing of ideas and information pertaining to any member dissatisfaction is encouraged. These groups seek provider feedback and provide information in a framework that allows the health plan to develop a true partnership with their provider network.

The health plan is performing credentialing audits following URAC and NCQA standards. The health plan policies and procedures were reviewed and were in compliance with both the SMA contract requirements and the federal regulations.

Member Services staff and Case Managers do not have a lot of impact in the area of Structure and Operation Standards. However, they both related that

they do assist members if they have provider issues or problems. They then refer these issues to Provider Relations for follow-up.

Ratings for compliance with Structure and Operation Standards (100%) reflected completed and approved policy and procedures in this area for the second year.

Table 70 – Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison (HCUSA)

Federal Regulation	HealthCare USA		
	2005	2006	2007
438.214(a,b) Provider Selection: Credentialing/Re-credentialing	2	2	2
438.214(c) and 438.12 Provider Selection: Nondiscrimination	2	2	2
438.214(d) Provider Selection: Excluded Providers	2	2	2
438.214(e) Provider Selection: State Requirements	2	2	2
438.226 and 438.56(b)(1-3) Disenrollment: Requirements and limitations	1	2	2
438.56(c) Disenrollment Requested by the Enrollee	1	2	2
438.56(d) Disenrollment: Procedures	1	2	2
438.56(e) Disenrollment: Timeframes	2	2	2
438.228 Grievance System	2	2	2
438.230(a,b) Subcontractual Relationships and Delegation	1	2	2
Number Met	6	10	10
Number Partially Met	4	0	0
Number Not Met	0	0	0
Rate Met	60.0%	100.0%	100.0%

Note: 0 = Not Met; 1= Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols.

Measurement and Improvement

The MO HealthNet Managed Care health plan continued to use InterQual as a guide for decision-making in terms of utilization review. InterQual criteria were originally cited when asked about practice guidelines. The health plan has instituted a number of practice guidelines and has instituted a number of initiatives to ensure their distribution to and use by providers. HealthCare USA's Medical Director does ensure that monitoring utilization of practice guidelines is occurring at the provider level.

HealthCare USA continued to have a well developed internal written quality assessment and improvement program. The health plan shared their Quality Management Charter and minutes from meetings. The Quality Management

Program focused on monitoring, assessment, and evaluation of clinical and non-clinical service delivery. The result has been the implementation of quality programs that targeted members with special healthcare needs, but also provided enhanced services to all members. HealthCare USA indicated that they recognized the need to stratify data by region. The Quality Management charter ensured that meetings occur at least quarterly on a regular schedule and had representatives from all sections of the organization, as well as including providers. The quality management process ensured that the health plan maintained a record of activities, recommendations, accomplishments, and follow-up.

Through the administrative method, the health plan did report data for Validating Performance Measures.

The health plan did submit clinical and non-clinical Performance Improvement Projects. The details of the audit are located in the appropriate section of this report. The MCHP continued to operate a health information system that meets required standards. Encounter data was submitted in the format requested so that appropriate validation could occur. The details of this process are located in the Validating Encounter Data section of this report.

Ratings for compliance with Measurement and Improvement regulations (100%) reflect the completion of all policy and procedures in this area for the second year. The health plan did submit all data in requested formats, allowing the proper validation process to occur.

Table 71 – Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement Yearly Comparison (HCUSA)

Federal Regulation	HealthCare USA		
	2005	2006	2007
438.236(b)(1-4) Practice Guidelines: Adoption	2	2	2
438.236(c) Practice Guidelines: Dissemination	1	2	2
438.236(d) Practice Guidelines: Application	1	2	2
438.240(a)(1) QAPI: General Rules	2	2	2
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCHP Quality Improvement and PIPs	1	2	2
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	1	2	2
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	2	2	2
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	2	2	2
438.240(e) QAPI: Program Review by State	NA	NA	NA
438.242(a) Health Information Systems	2	2	2
438.242(b)(1,2) Health Information Systems: Basic Elements	2	2	2
438.242(b)(3) Health Information Systems: Basic Elements	2	2	2
Number Met	7	11	11
Number Partially Met	4	0	0
Number Not Met	0	0	0
Rate Met	63.6	100.0%	100.0%

Note: Regulation 438.240(e) refers to program review by the state. The regulation requires the state to review, at least annually, the impact and effectiveness of each MCHP's quality assessment and performance improvement program. The regulation refers to the state QA & I program review process and is not applicable to External Quality Review of the MC+ Managed Care Program. This percent is calculated for the regulations that are applicable to the MC+ Managed Care Program. 0 = Not Met; 1 = Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols.

Grievance Systems

Rating for compliance with Grievance Systems regulations (100%) indicates that the MCHP completed all requirements regarding policy and practice in their grievance system. This is the fourth year that HealthCare USA has been 100% compliant in the area of Grievance Systems and reflects that the health plan considers this an important aspect of compliance in both policy and practice. Out-of-network providers are informed of policies and procedures regarding

complaints, grievances and appeals through the Provider Manual and Web Link.

The health plan has resolved to obtain timely grievance resolution for both members and providers. The grievances are placed in their CSO system, which tracks timeframes and generates notices and letters. Specific staff is assigned to appeals for members. They assist in obtaining the most complete information to present to an appeals committee. The member is notified by telephone and in writing of the decision to ensure that they have the information as quickly as possible. HealthCare USA utilizes an appeals form for members and does provide assistance with the written request for an appeal.

Member Services staff indicate that they receive information or contact from members that they immediately recognize as grievances and appeals. They listen to members, record information and refer the situation to the Grievance Department. The Members Services staff shared that sometimes a member does wish to pursue the issue as a grievance or appeal, but they make a referral with a notation that the member does not wish to have their name revealed. These usually concern provider issues that will need follow-up to resolve. They also relate that grievances and appeals are reviewed in quarterly meetings. There is a great deal of communication between departments regarding the findings and analysis.

During the Member Services and Case Management interviews it was learned that these staff are not integrally involved in the Grievance and Appeal process. As a result a short interview occurred with members of the Grievance Department. They reported that the health plan receives approximately sixty grievances per month, forty appeals per month, and 1-2% may become a State Fair Hearing. They estimated that 75% of calls come directly from members.

The Grievance Department staff gave the example of a member calling about

an adverse authorization decision. The Compliance Analyst informs the member on how to proceed through the appeal process. The member is made aware of their rights and is given assistance in moving throughout the process. Outside physicians are utilized for review of the case and responsible for the final appeal decision. The Compliance Analysts all reported that adverse decisions are often the result of a lack of complete medical information. When additional information is available the denial is overturned. All decisions are recorded in the health plan system, and appropriate correspondence is sent to members and providers.

Table 72 – Subpart F: Grievance Systems Yearly Comparison (HCUSA)

Federal Regulation	HealthCare USA		
	2005	2006	2007
438.402(a) Grievance and Appeals: General Requirements	2	2	2
438.402(b)(1) Grievance System: Filing Requirements - Authority	2	2	2
438.402(b)(2) Grievance System: Filing Requirements - Timing	2	2	2
438.402(b)(3) Grievance System: Filing Requirements - Procedures	2	2	2
438.404(a) Grievance System: Notice of Action - Language and Format	2	2	2
438.404(b) Notice of Action: Content	2	2	2
438.404(c) Notice of Action: Timing	2	2	2
438.406(a) Handling of Grievances and Appeals: General Requirements	2	2	2
438.406(b) Handling of Grievance and Appeals: Special Requirements for Appeals	2	2	2
438.408(a) Resolution and Notification: Basic Rule	2	2	2
438.408(b,c) Resolution and Notification: Grievances and Appeals - Timeframes and Extensions	2	2	2
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	2	2	2
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	2	2	2
438.410 Expedited Resolution of Appeals	2	2	2
438.414 Information about the Grievance System to Providers and Subcontractors	2	2	2
438.416 Recordkeeping and Reporting Requirements	2	2	2
438.420 Continuation of Benefits while Appeal/Fair Hearing Pends	2	2	2
438.424 Effectuation of Reversed Appeal Resolutions	2	2	2
Number Met	18	18	18
Number Partially Met	0	1	0
Number Not Met	0	0	0
Rate Met	100%	100%	100%

Note: 0 = Not Met; 1= Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols

CONCLUSIONS

HealthCare USA continued to exhibit a commitment to completing, submitting and gaining approval of required policy and procedures by the SMA. The health plan maintained improvements to achieve 100% compliance in all sections of the protocol for the second year. The operations and practices revealed during interviews at the on-site review indicated a commitment by HealthCare USA to provide quality healthcare services to its members. Health Plan activities focused on: enhancing preventative services; creating new approaches to providing access to services such as the development of after-hours clinics; obtaining member input on issues; in engaging provider input into improving and delivering services effectively; and responding to prior authorizations and grievances in a timely and efficient manner.

The health plan incorporated methods to track required policy submission into daily administrative practice and took this process seriously. The practice observed at the time of the on-site review provided confidence that the health plan made service to members their primary focus and that there was a commitment to comply with the requirements of the MO HealthNet Managed Care contract and federal regulations.

It is also noted that all staff interviewed reflected the health plan's culture of respect for member and the priority for meeting member service needs. Staff members were open and animated in their responses. They were eager to give examples of how they assist members in normal and extraordinary circumstances.

QUALITY OF CARE

The staff at HealthCare USA exhibits a commitment to excellence that creates an atmosphere where both members and providers experience quality services.



The provider relations staff made regular contacts with providers to troubleshoot problems that may be reported by members, and to assist provider staff in making interactions with members and the health plan less complicated. Efforts within the communities served, involvement with FQHCs, and with Community Mental Health Clinics, are examples of working to produce quality care in the most convenient environment, and working to improve access to care for members. These relationships have also allowed education to occur that improves the quality of services for both the member and organizational level. Member Services and Case Management staff related the importance placed on training and collaboration to ensure that they are aware of issues that may arise and can respond quickly and efficiently to ensure that members have access to quality health care.

ACCESS TO CARE

HealthCare USA provided numerous examples of initiatives they are involved in to ensure that members have information on obtaining services and have adequate access to services. Several projects bring providers directly to places where members are available. The health plan has also undertaken provider recruitment and retention efforts that ensure that providers are available to members throughout all three Regions served.

Internally HealthCare USA, as an organization, has made efforts to ensure interdepartmental integration to create thorough knowledge of their service delivery system thus enabling staff to assist members effectively. Staff exhibited enthusiasm in describing the services they deliver and a desire to ensure that members' health care needs are met in spite of the barriers sometimes experienced.

TIMELINESS OF CARE



The health plan was able to complete all required policies and procedures in a timely manner, to ensure compliance with State contract requirements and federal regulations. This effort reflects the attention needed to be able to focus on member service needs. HealthCare USA has also initiated a number of practices that enhanced timely response and resolution of grievances and appeals for both members and providers. This decision making process enables members to obtain the healthcare they require in a timely manner. The health plan recognizes the importance of timely and adequate services.

RECOMMENDATIONS

1. Maintain the importance of complying with documentation requirements to the same standards as those reflected in the daily practice within the health plan.
2. Continue health plan development in the area of utilization of available data and member information to drive change and support opportunities for organizational growth and development.
3. Continue to track policies and other materials required for annual review.
4. Continue the commitment to oversight of subcontractors, such as MHNet and Doral Dental. Quarterly reviews ensure that member services are at the level the MCHP requires.
5. Maintain involvement in community-based services and activities.
6. Continue training efforts with front line staff to ensure that they are versed in health plan policy and procedures and remain confident in their interactions with and advocacy for members.

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10.0 Mercy CarePlus

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10.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

Mercy CarePlus supplied documentation for review of two:

- 2007 Emergency Room Utilization
- 2007 Early Intervention in Prenatal Case Management and the Relationship to Very Low Birth Weight Babies

INTERVIEWS

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on July 8, 2008 during the on-site review at the St. Louis, Missouri offices of the health plan, and included the following:

Dr. Robert Profumo – Medical Director
Jennifer Goedeke – Director - Quality Improvement
Cherie Brown – Manager, Case management/Pre-Authorization
April Gross, RN – Complex Case Manager
Diane Jellison, RN – Complex Case Manager
Nancy Zmuda – Director, Utilization Management

The interviewees shared information on the validation methods, study design, and findings. Technical assistance regarding study design and presentation of findings was provided by the EQRO. The following questions were addressed:

- Who were the members of the staff involved with the project and what were their roles?
- How was the topic identified and the choice justified ensuring that the PIP truly addressed an important aspect of member care and services?

- How was the study question determined?
- What were the interventions?
- What was the time period of the study and is it complete?
- What were the findings?
- Were the interventions effective?
- What does Mercy CarePlus want to study or learn from their PIPs?
- Is Mercy CarePlus utilizing the Performance Improvement Project process to enhance internal procedures and to improve member services and healthcare?

The PIPs presented did not originally provide enough documentation to allow for a thorough validation of the findings. Additional time was provided for Mercy CarePlus to supply an update of both Performance Improvement Projects prior to final evaluation.

FINDINGS

The first, Emergency Room Utilization was originally evaluated in 2006. This project was re-evaluated for the 2007 External Quality Review. In 2006 Mercy CarePlus submitted documentation for Emergency Room Utilization for Asthma-Related Diagnoses for 5-18 Year Olds at Cardinal Glennon Hospital as their non-clinical performance improvement project. This Performance Improvement Project was revised for the 2007 review year and was resubmitted as the non-clinical PIP entitled "Emergency Room Utilization." The second Performance Improvement Project submitted was Early Intervention in Prenatal Case Management and the Relationship to Very Low Birth Weight Babies. This PIP was submitted as the health plan's clinical performance improvement project, which is also a re-evaluation of a previously submitted project. This review includes information indicating whether or not the re-evaluation of these Performance Improvement Projects provides any trends in:

- improvement rates for the studies;
- improvement in satisfaction; or
- overall improvement in member services.

The original PIP, “Emergency Room Utilization (Children Receiving Emergency Room Services at Cardinal Glennon Hospital)” was evaluated during the 2005 and 2006 EQR. The focus of this study remained unclear due to fundamental changes in the study topics. The original study was designed to reduce the incidents of emergency room visits at one St. Louis area children’s hospital. Beginning in October 2005, the study was narrowed to address “Emergency Room Utilization for Asthma-Related diagnoses for Children 5 – 18 years at Cardinal Glennon Hospital.” The current study, conducted throughout 2007, focused on members using the emergency rooms for non-emergent medical visits, rather than visiting their primary care physician (PCP) or an Urgent Care Center (UCC). The study question for the current topic has been revised. The current study questions are: 1) Do MCP members with frequent Emergency Department (ED) use, defined as three or more ED visits in any three-month period, represent persons who have increased and/or unmet medical needs causing an increase in ED utilization? 2) If unmet needs are identified, can Complex Case Management (CCM) provide education and resources, which will allow these members to obtain medical care at a more appropriate setting and in conjunction with their Primary Care Physician (PCP) and thus, reduce ED utilization? 3) In members with frequent ED use who do not have unmet needs, can education on alternative care options (PCP, UCC, home treatment) by the CCM team reduce unnecessary ED visits? This expanded set of questions creates a complex, but more in-depth approach to investigating this study topic. These questions provide a clear direction to the study, and illustrate how the study will be measured. The narrative does provide justification for the choice of topic. The presentation uses local health plan data and information, supported by a literature review and other research to support the choice of this issue as a salient topic to improve organizational functions and services to a possibly fragile set of members. The population included any member utilizing emergency room services three or more times in any three-month period. The population did not

exclude any member with special needs, but conversely believed it would identify members in need of complex case management who may have unmet special needs. There was no sampling conducted.

The revised hypothesis presented is as follows:

- MCP Members with frequent ED use represent a subset of members with increased and/or unmet medical needs causing an increase in ED utilization;
- Complex Case Management can decrease the rate of frequent ED utilization via member education, removal of barriers to care, and increased coordination of care through the PCP; and
- The MCP Case Management Team can offer members with frequent ED utilization alternatives to seeking care in the ED in order to educate members that not all acute situations require a visit to the ED; many situations can be treated safely at home, at the PCP office or at an Urgent Care Center.

The objective of the study is to reduce the number of emergency room visits and improve the use of primary care physicians or urgent care resources. The study narrative provides information on how data on identified indicators were measured. The original methods proved to be inaccurate or untimely in identifying the members in question. Specific clear measurable indicators and how information was reported is clarified in the most recent updates. Needed changes were mentioned, a new reporting methodology was provided. Study indicators explaining how individuals, as well as the general MCP population using ED services, were tracked and approached with CCM services was included in the narrative. The individuals involved in the study, including the CCM team was defined including team member roles and qualifications. All internal resources used in researching identified member history and services were utilized and defined. Health plan policy outlining the expectations for this level of medical management was included.

The PIP does indicate how ED visits are tracked by member, or how members are tracked to identify a recurrence of ED visits. It does indicate how new members or new ED visits are identified. The information provided identified members who were receiving case management services, those newly enrolled in case management services based on the parameters of the PIP. It provided clarification on how these services were used, or how they impacted the members' decisions regarding the use of ED services, rather than primary care physician services or urgent care resources.

The interventions, or complex case management processes include:

- Education about the benefits as an MCP member
- Discussion of chronic medical/psychiatric conditions
- Evaluation of unmet medical/psychiatric needs
- Education and links to community resources
- Offer of inclusion in relevant disease management programs

- Education on the situations that require emergent medical care, as opposed to urgent and routine situations
- Removal of barriers such as the provision of transportation to a PCP or UCC
- Discussion on the importance of compliance with prescribed medications and therapies

- Provision of the name and location of the nearest UCC along with an explanation of the appropriate reasons for using a UCC
- Direction to the appropriate provider if the member is in need of specialty care
- Analysis of the potential for pharmacy lock-in if the member is noted to be going to multiple EDs and receiving narcotic prescriptions
- Education about the purpose of the MCP Nurse Advice Line, as a resource for member use
- Education of the importance of using a PCP as a medical home and the provision of the member's PCPs name, address, and phone number, as well as encouragement to call the PCP for a follow-up appointment

The study did include results for the third and fourth quarters of 2007. It appears from the data gathered and analyzed to date that the hypothesis and interventions are sound and have a high probability of having a positive impact on member behavior and access to services. It is difficult to determine the statistical effectiveness of the interventions to date. The study did include a detailed methodology for retrieving demographic and other pertinent data. The study explained the sources for the data retrieved, and validated their reliability.

The study utilized a specific study design and systematic method of collecting valid and reliable data. The future improvement strategies, interventions and analysis were described to ensure that the study would continue and have ongoing results to report. Diagrams and graphs were presented for the two quarters where data was available. Data sources are defined, and assure that complete and accurate data will be collected. Charts include information on frequent ED users. How these charts and graphs are related to the hypotheses and how this information relates to anticipated outcomes is described.

The future of planned interventions is defined. The effect of the interventions and

how they will be measured is provided. The study narrative describes that if the planned interventions continue to have the positive impact that has been experienced thus far, it will create a decreased frequency of inappropriate use of emergency room services. The health plan describes the environment for sustained improvement and the assumption that the need for complex case management for the same members should decrease if the effectiveness of the interventions continue.

The information that was made available to the EQRO does not allow for in-depth analysis of the PIP to date. However, the information provided does provide confidence that this study has a strong potential for a positive and sustained improvement in member services and outcomes. The outline of the project should develop into a meaningful method of improving services to members. A detailed explanation is presented of how the data collected will be used, what the expected outcomes of the planned interventions are, and how these interventions will improve health care services for members. The study has potential for real and sustained improvement if it continues to be conducted in a structured and meaningful manner.

The second PIP evaluated was the clinical submission entitled, “Early Intervention in Prenatal Care Management and the Relationship to Very Low Birth Weight Babies.” This project asked if increased rates of obstetrical case management would positively affect birth outcomes. The study specifically seeks to assess whether increased rates of case management for all pregnant members would lead to decreases in the incidence of very low birth weight babies. Low birth weight was defined as babies weighing less than 2500 grams, very low birth weight babies were defined as weighing less than 1500 grams, and extremely low birth weight was defined as babies weighing less than 1000 grams at birth. The study topic was well supported by a literature review and a review of issues relevant to health plan members. Resource information was quoted and used to

create an argument for this study. This is the health plan's submission as a clinical performance improvement project. The study justification included information on the physical, social and emotional costs for members associated with low and very low birth rate infants. It also discussed, on the practical side, the monetary costs that care for the mothers and infants create for the health plan. The focus of the study is improved services and outcomes for members. A pertinent issue is also a decrease in expenditures for the health plan. The stated goal of the project is to decrease the rate of preterm deliveries through aggressive obstetrical case management.

The steps taken by Mercy CarePlus included early intervention and implementation of case management for all pregnant members. The goal was to increase members' access to prenatal care in an effort to ensure all appropriate health care was received thereby reducing the incidence of low, very low, and extremely low birth weight deliveries. The health plan found that national trends indicated an increase in very low birth weight deliveries. In the original study Mercy CarePlus's stated goal was for their trend data to remain flat, however, the current goal is to decrease the rate of preterm deliveries through aggressive OB case management.

The study question is "Does an increased rate of OB case management affect birth outcomes? Specifically, will increased rates of OB case management lead to a decrease in the rate of low birth weight, very low birth weight, and extremely low birth weight babies?" This question is well constructed and provides direction to the study and outlines the study parameters. The original goal to "remain flat" did not appear to have a significant impact on the identified population. With the expanded goal of decreasing the rate of low birth weights the study promised to have a more profound impact of the population served. The population was defined to include any MCP member who was pregnant. Members to be included in the study were to be identified

by the following methods of notification:

- Pregnancy Risk Screening Forms
- Baseline Health Assessment
- Hospital Admissions and Observations
- Welcome Calls
- OB Provider Referrals

The study indicators attempted to provide for early identification of members who were pregnant and early implementation of case management services. The study did include levels of risk, which determined the intensity of case management services. A Pregnancy Risk Screening tool was used to evaluate pregnant members and to ensure the proper level of case management and ancillary services were provided to all pregnant members. The entire case management intervention was well described. The stated decision-making process for determining the level of care was “clinical and past experience.” This methodology was described in detail providing confidence in the decision-making criteria to determine risk. The information included a risk matrix that assisted in standardizing the decision-making process. As the study matured, changes were made to increase the effectiveness of the interventions. During the first six months of 2007 Mercy CarePlus case-managed high risk pregnancies. Throughout the remainder of the study all pregnancies were case-managed. More significant outcomes were found as the result of this added component.

The narrative included a planned data analysis, a description of the measurement methodology, and data collected. This was reflected on the graphs and tables presented in the study. The expanded information provided includes an explanation of the process utilized to collect data and an explanation of the measurement cycles. This additional information assisted in defining causes and variables that may impact the expected outcomes. During the period in which this study was in process the health plan experienced a

merger with another plan. The effect of adding members and other variables that occurred as the result of this merger were discussed in the documentation provided. A brief explanation of the resulting growth in membership and how birth outcomes are standardized to membership is included.

The study information does identify the Medzilla case management system as the source used to collect data and produce reports. Some confusion remains about the information included in the reports and the actual data included. The information these reports provided was not clarified or explained in any detail. In some instances what the reports included has to be assumed. The narrative provided assumed a systematic method for valid and reliable data collection. Additional explanation of the data attached would assist evaluators in determining whether consistent and accurate data was collected throughout the study period. Pre and post-intervention analysis asserts a positive impact from the case management intervention. However, the narrative does not provide statistical significance testing or other evaluative tools other than comparing rate data. This creates difficulty in determining the validity and effectiveness of the intervention over time. The study did provide a baseline and two additional years' statistics. Conclusions were drawn from the data presented. The study asserted that the increased case management could be considered an effective intervention based on the decrease in low, very low and extremely low birth weights. Information provided defended this conclusion. However, it should be noted that the data presented appeared to provide evidence that the study did result in credible and interpretable findings.

The stated goal of this study was to achieve a decrease in the incidences of low, very low, and extremely low birth weight infants. Initially the study did not indicate that it would measure any variable factors, such as increased or decreased number of pregnancies, the increased or decreased number of members obtaining case management, or the influence of earlier determination

of risk for the pregnant women. The improved study that began in June 2005 does include some of this information. The study continued during 2006 and 2007. The outcomes were evaluated over this time period. The planned interventions did appear to have a positive impact on MO HealthNet Members.

Additional narrative discussing the impact of variables and defending the outcome of the study are crucial to be able to draw an informed conclusions about the impact of the study interventions. It should be noted that this study can inform not only Mercy CarePlus, but all MO HealthNet Managed Care health plans, about the importance of this type of approach to impacting members' healthcare and behavior. The study communicates the importance of this approach. With some additional clarity and explanation of the data available, the approach devised in this study could be considered a best practice in impacting member behavior and member outcomes.

CONCLUSIONS

QUALITY OF CARE

The best care in the most appropriate environment is the assumed focus of the first PIP. The interventions attempted to incorporate methods to ensure that members sought services in a timely and appropriate manner, which would improve the quality of their lives as well as of the care received.

It appears that Mercy CarePlus has begun utilizing the PIP process to inform the organization about the most effective methods to improve and provide quality healthcare. The health plan states a desire to incorporate positive outcomes from the PIP into organizational operations. They articulate plans to use the PIP process to assist in program enhancement and organizational development in an effort to improve member services.

In the second PIP, the health plan sought to not only enhance the care pregnant women received, but also the quality of life for newborns, whose mothers received sound prenatal services. The pregnant women served received a variety of services that they may never have been aware of if they did not have access to the additional case management provided. The outcomes of the pregnancies followed during this period led to a decrease in the number of low, very low, and extremely low birth weights. The health plan asserts that giving newborns a healthier start will enable improved outcomes in the quality of their lives. The narrative stated that this program will be continued as part of Mercy Care Plus's routine case management process.

ACCESS TO CARE

The focus of the first PIP does address access to care, and it is an overtly stated goal of the project. The intention of the interventions is to ensure that members' have the best care in the best environment. By ensuring that members are aware of their PCP, or of available urgent care resources, and the services available in the office setting, rather than in an emergency room, members will be able to chose to receive care in a more appropriate environment. Using the Complex Case Management approach does provide strong advocacy for members and greatly improves the information they have available to make informed health care choices.

The second PIP did enable members to have early access to prenatal care and intensive case management when appropriate. Using the case management process as early in members' pregnancy as possible provided the opportunity to inform members of all health plan services available to them, and to ensure that they had access to the provider of their choice whenever possible. When members were identified as "high risk," access to in-home as well as obstetrical

care created additional access to a broad variety of supportive services. This PIP created an environment for fundamental preventive services by enhancing members' access to early and adequate healthcare.



TIMELINESS OF CARE

The educational efforts of the first PIP were implemented in an attempt to encourage members to obtain the most timely and effective care possible. Members receiving treatment in a PCP office setting, or in an urgent care environment, rather than waiting until a crisis occurs and using emergency room treatment are much better served. In the second PIP the issue of timeliness is one of the essential components of providing the best services through the case management efforts provided. Mercy CarePlus made significant efforts to ensure that members obtained necessary medical services at early stages of pregnancy thereby ensuring the increased number of healthy births experienced.

RECOMMENDATIONS

1. The study design of Performance Improvement Projects should link the questions, the interventions, and the proposed outcomes to determine whether or not an intervention was effective. This can be accomplished by developing a logic model for the PIPs at the planning stage, and ensuring that adequate narrative accompanies the data and information presented to make all necessary connections.
2. Quarterly measurement should be utilized if at all possible. This will provide information on the ongoing effects of the planned program. Data analysis should incorporate methods to ensure that any resulting change, or lack of change, was related to the intervention.
3. Provide enough narrative to ensure that the reader understands the problem, the proposed interventions, the goals and outcomes hoped for, and how the data presented relates to all these issues and either supports program improvement, or is not effective. Narrative should also be provided to defend the conclusions and defined outcomes of the study.

This will provide justification, particularly if the process is to be an ongoing change in the health plan operations.



10.2 Validation of Performance Measures

METHODS

This section describes the documents, data, and persons interviewed for the Validation of Performance Measures for Mercy CarePlus. Mercy CarePlus submitted the requested documents on January 28, 2008. The EQRO reviewed documentation between January 28, 2008 and July 1, 2008. On-site review time was used to conduct follow-up questions and provide feedback and recommendations regarding the performance measure rate calculation.

DOCUMENT REVIEW

The following are the documents reviewed by the EQRO:

- The Baseline Assessment Tool (BAT) submitted by Mercy CarePlus (prepared by Novasys)
- Healthcare Research Associates' (HRA) HEDIS 2007 Compliance Audit Report
- NovaSys Health Network, LLC, policies and procedures related to the HEDIS rate calculation process.
- NovaSys Health Network, Mercy CarePlus electronic eligibility process
- Data files from the HEDIS repository containing eligible population, numerators and denominators for each of the three measures
- Decision rules & queries in the HEDIS 2007 repository used to identify eligible population, numerators and denominators for each of the three measures
- Query result files from the repository

The following are the data files submitted by Mercy CarePlus for review by the EQRO:

- A (01) FUH File 1 Export to BHC.txt
- B (01) FUH File 2 Export to BHC.txt

- C (01) AWC File 1 Export to BHC.txt
- D (01) AWC File 2 Export to BHC.txt
- E (01) HEDIS Bridgeport EM for BHC.txt
- EQRO Bridgeport 11708.txt

INTERVIEWS

The EQRO conducted on-site interviews with Mike Alvornoz, Molina Corporate Director, Jennifer Goedeke, Quality Improvement Manager, Robert Profumo, Medical Director, Ainette Martinez (representing Bridgeport Dental) and Michael Boone and Steve Sheldon (representing Novasys) on Tuesday, July 8, 2008. Michael Boone and Steve Sheldon of Novasys were responsible for calculating the HEDIS 2007 performance measures of Follow-Up After Hospitalization for Mental Illness and Adolescent Well-Care Visits, and Bridgeport Dental provided the Annual Dental Visit rate.

FINDINGS

Mercy CarePlus calculated the Adolescent Well-Care Visits, Annual Dental Visit, and Follow-up After Hospitalization measures using the Administrative Method. MO HealthNet Mangaed Care health plan to MO HealthNet Managed Care health plan comparisons of the rates of Annual Dental Visit, Adolescent Well-Care Visits, and Follow-Up After Hospitalization for Mental Illness were conducted using two-tailed z-tests. For comparisons that were statistically significant at the 95% confidence interval (CI), the z-score (z), the upper and lower confidence intervals (CI), and the significance levels ($p < .05$) are reported.

The HEDIS 2007 rate for Mercy CarePlus for the Adolescent Well-Care Visits measure was 29.49%, which was significantly lower than the statewide rate for all MCHPs (34.81%; $z = -0.33$, 95% CI: 28.89%, 40.74%; $p < .05$). However, this rate was much higher than the rate (18.75%) reported by this health plan during the 2004

EQR report.

The HEDIS 2007 rate for the Follow-Up After Hospitalization measure is reported as two rates, one for 7-day follow-up and one for 30-day follow-up. The Follow-Up After Hospitalization rates reported to the SMA and the State Public Health Agency (SPHA) by Mercy CarePlus were 24.68% (7-day rate) and 46.31% (30-day rate). The 7-day rate reported was significantly lower than the statewide rate for all MO HealthNet Managed Care health plans (35.52%; $z = -0.34$, 95% CI: 22.96%, 48.08%; $p < .05$); this rate was also lower than the 7-day rate (25.30%) reported by the health plan during the 2006 review. . The 30-day rate reported was consistent with the statewide rate for all MO HealthNet Managed Care health plans (60.06%; $z = 1.38$, 95% CI: 47.50%, 72.62%; $p < .05$); however, this rate was lower than the 30-day rate (49.10%) reported by the health plan during the 2006 review.

The reported rate for Mercy CarePlus for the Annual Dental Visit rate was 30.45%. This was consistent with the statewide rate for MO HealthNet Managed Care health plans (32.50%, $z = 0.04$; 95% CI: 29.30%, 35.69%; n.s.); however this rate is lower than the rate (31.13%) reported by the health plan during the 2005 review.

The following sections summarize the findings of the process for validating each of the performance measures in accordance with the Validating Performance Measures Protocol. The findings from all review activities are presented according to the EQRO validation activity, with the findings for each measure discussed within the activities as appropriate. Please refer to the tables in the main report for activities, ratings, and comments related to the CMS Protocol Attachments.

DATA INTEGRATION AND CONTROL



Information systems management policies and procedures for rate calculation were evaluated consistent with the Validating Performance Measures Protocol. This included both manual and automatic processes of information collection, storing, analyzing and reporting. The EQRO was provided with a demonstration of the HEDIS repository. This was done through a remote connection from the Mercy CarePlus location in St. Louis to the vendor's system in Little Rock, Arkansas.

For all three measures, Mercy CarePlus was found to meet all of the criteria for having procedures in place to produce complete and accurate data (see Attachment V: Data Integration and Control Findings). There were no biases or errors found in the manner in which Mercy CarePlus transferred data into the repository used for calculating the HEDIS 2007 measures.

DOCUMENTATION OF DATA AND PROCESSES

Data and processes used for the calculation of measures were adequate (see Attachment VII: Data and Processes Used to Calculate and Report Performance Measures). Mercy CarePlus met all criteria that applied for all three measures.

PROCESSES USED TO PRODUCE DENOMINATORS

Mercy CarePlus met all criteria for the processes employed to produce the denominators of all three performance measures (see Attachment X: Denominator Validation Findings). This involved the selection of members eligible for the services being measured.

The Well-Care Visits measure contained an eligible population of 8,470. The EQRO found the age ranges, dates of enrollment, medical events, and continuous enrollment criteria were programmed to include only those members who met HEDIS 2007 criteria.

For the Follow-Up After Hospitalization measure, a total of 393 eligible members were reported and validated by the EQRO.

A total of 20,617 eligible members were reported and validated for the Annual Dental Visit measure.

PROCESSES USED TO PRODUCE NUMERATORS

All three measures included the appropriate administrative data ranges for the qualifying events (e.g., well-care visits, follow-up visits, or dental visits) as specified by the HEDIS 2007 criteria (see Attachment XIII: Numerator Validation Findings). No medical record reviews were conducted.

For the Adolescent Well-Care Visits measure, there were a total of 2,457 administrative hits found in the data file; the health plan reported a total of 2,498

hits. Thus, the rate validated by the EQRO was 29.01% and the rate reported by the health plan was 29.49%, resulting in a bias of 0.48%.

The Follow-Up After Hospitalization for Mental Illness measure 7-day rate contained a total of 97 administrative numerator events reported, of which all 97 were able to be validated by the EQRO. Thus, the rate validated by the EQRO and the rate reported for this measure were the same (24.68%), resulting in no bias. For the 30-day follow-up rates, the EQRO validated 182 hits and the health plan reported 182 hits. This resulted in a rate of 46.31% found by both the EQRO and the health plan, indicating no bias found.

The number of Annual Dental Visit hits reported by the health plan was 6,278; the EQRO was able to validate a total of 6,273. The rate reported by the health plan was 30.45% and the rate validated by the EQRO was 30.43%; this resulted in a 0.02% estimated bias (overestimate) by Mercy CarePlus.

SAMPLING PROCEDURES FOR HYBRID METHODS

No medical record reviews were conducted or validated. CMS Protocol Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings do not apply to the Administrative Method.

SUBMISSION OF MEASURES TO THE STATE

Mercy CarePlus submitted the DST for each of the three measures validated to the SPHA (the Missouri Department of Health and Senior Services; DHSS) in accordance with the Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) and the SMA Quality Improvement Strategy.

DETERMINATION OF VALIDATION FINDINGS AND CALCULATION OF BIAS



The following table summarizes the estimates of bias and the direction of the bias. There was no bias found for the Follow-Up After Hospitalization for Mental Illness measure. The rates for the Adolescent Well-Care Visits and Annual Dental Visit measures were slightly overestimated. However, both were within the 95% confidence interval for the rates reported by the health plan.

Table 73 - Estimate of Bias in Reporting of MCP HEDIS 2007 Measures

Measure	Estimate of Bias	Direction of Estimate
Adolescent Well-Care Visits	0.48%	Overestimate
Follow- Up After Hospitalization (7 days)	No bias	n/a
Follow-Up After Hospitalization (30 days)	No bias	n/a
Annual Dental Visit	0.02%	Overestimate

FINAL AUDIT RATING

The Final Audit Rating for each of the performance measures was based on the findings from all data sources summarized in the Final Performance Measure Validation Worksheet for each measure.

Table 74 - Final Audit Rating for MCP Performance Measures

Measure	Final Audit Rating
Adolescent Well-Care Visits	Substantially Compliant
Follow- Up After Hospitalization (7 days)	Fully Compliant
Follow-Up After Hospitalization (30 days)	Fully Compliant
Annual Dental Visit	Substantially Compliant

Note: Fully Compliant = Measure was fully compliant with State specifications; Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate; A significant bias in the rate was defined as a number calculated by the EQRO that fell outside the 95% confidence interval of the rate reported by the health plan. Not Valid = Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported; Not Applicable = No MO HealthNet Managed Care Members qualified for the measure.

CONCLUSIONS

Four rates were validated for the health plan. Two of these rates were consistent

with; and two were significantly lower than the average for all MO HealthNet Managed Care Health Plans.

QUALITY OF CARE

Mercy CarePlus's calculation of the HEDIS 2007 Follow-Up After Hospitalization for Mental Illness measure was fully compliant with specifications. This measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care delivered. MCP's 7-day rate for this measure was significantly lower than the average for all MO HealthNet Managed Care health plans; the 30-day rate was consistent with the average. These rates are also lower than the rates for the same measure reported by the health plan during the 2006 review. Therefore, MCP's members are receiving a lower quality of care for this measure within the 7-day timeframe than the average MO HealthNet Managed Care member, and are receiving a quality of care for this measure consistent with the care delivered to the average MO HealthNet Managed Care member within the 30-day timeframe.

The EQRO was able to fully validate the rate reported by the health plan for this measure and therefore is extremely confident in the health plan's reported rate.

ACCESS TO CARE

CarePlus's calculation for the HEDIS 2007 Annual Dental Visit measure was substantially compliant with specifications; this measure is categorized as an Effectiveness of Care measure. Because only one visit is required for a positive "hit", this measure effectively demonstrates the level of access to care that members are receiving. The rate reported by MCP for this measure was consistent with the average for all MO HealthNet Managed Care health plans; however this rate was lower than the rate reported by the health plan during the 2005 EQR. Although this rate was higher than the rate reported by the health plan during the 2004 report, MCP's members are receiving a quality of care that

is consistent with the care delivered to the average MO HealthNet Managed Care member.

The EQRO was able to validate this rate within the reported 95% confidence interval and therefore has confidence in the calculated rate.

TIMELINESS OF CARE

Mercy Care Plus's calculation of the HEDIS 2007 Adolescent Well-Care Visits measure was fully compliant. This measure is categorized as a Use of Services measure and is designed to measure access to and timeliness of the care defined. MCP's reported rate for this measure was significantly lower than the average for all MO HealthNet Managed Care health plans. Therefore, MCP's members are receiving a less timely level of care for this measure than the level of care delivered to the average MO HealthNet Managed Care health plan member.

The EQRO was able to validate this rate within the reported 95% confidence interval and thereby has confidence in the calculated rate.

RECOMMENDATIONS

1. The health plan's 7-day rate for Follow-up After Hospitalization for Mental Illness and Adolescent Well-Care Visits rate were significantly lower than the average rate for all MO HealthNet Managed Care Health Plans. The EQRO recommends the health plan concentrate efforts to improve these rates.
2. The health plan should consider the use of medical record review (when allowed by HEDIS specifications) as a way to improve reported rates.
3. Overall the health plans rates have trended down since the same rates were validated by the EQRO during previous External Quality Reviews.

The health plan should explore reasons for these trends and make every effort to reverse these downward trends.



10.3 Validation of Encounter Data

FINDINGS

The findings for the encounter data validation are organized according to the encounter data evaluation questions presented in the Technical Methods section for the encounter data validation in the aggregate report. Please refer to the main report for detailed objectives, technical methods and procedures for encounter data validation.

What is the Baseline Level of Completeness, Accuracy, and Reasonableness of the Critical Fields?

For the Medical claim type, there were 120,736 encounter claims paid by the SMA for the period July 1, 2007 through September 30, 2007.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Outpatient Recipient ID field was 100.00% complete, accurate and valid.
3. The Outpatient First Date of Service field was 100.00% complete, accurate, and valid.
4. The Outpatient Last Date of Service field was 100.00% complete, accurate, and valid.
5. The Outpatient Units of Service field was 100.00% complete, accurate and valid.
6. The Outpatient Procedure Code field was 100.00% complete, accurate, and valid.
7. The Outpatient Place of Service field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 100.0% complete, accurate and 97.40% valid.
9. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, all of these areas fell

well below the 100% threshold set by the SMA. The completeness, accuracy, and validity of the second, third, fourth, and fifth Diagnosis Code were 47.79%, 26.19%, 14.81%, and 0.00% respectively. The remaining fields were blank (incomplete, inaccurate, and invalid).

For the Dental claim type, there were 23,346 encounter claims paid by the SMA for the period July 1, 2007 through September 30, 2007. All fields examined were 100.00% complete, accurate and valid.

For the Home Health claim type, there was zero (0) encounter claims paid by the SMA for the period July 1, 2007 through September 30, 2007.

For the Inpatient claim type, there were 2,663 encounter claims paid by the SMA for the period July 1, 2007 through September 30, 2007.

1. The Inpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Recipient ID field was 100.00% complete, accurate and valid.
3. The Admission Type field was 100.00% complete, accurate and valid.
4. The Admission Date field was 100.00% complete, accurate and valid.
5. The Discharge Date field was 100.00% complete, accurate and valid.
6. The Bill Type field was 100.00% complete, accurate and valid.
7. The Patient Discharge Status field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 100% complete, accurate and valid.
9. The remaining Diagnosis Code fields fell well below the 100% threshold for completeness, accuracy, and validity established by the SMA. The second, third, fourth, and fifth Diagnosis Code fields were found to be 86.82%, 68.53%, 54.15%, and 42.32% complete, accurate, and valid, respectively. The remaining fields were blank (incomplete, inaccurate, and invalid).
10. The First Date of Service field was 100.00% complete, accurate, and valid.
11. The Last Date of Service field was 100.00% complete and accurate, and valid.
12. The Revenue Code field was 100.00% complete, accurate and valid.
13. The Units of Service field was 100.00% complete, accurate and valid.
14. For the Outpatient Hospital claim type, there were 59,669 encounter claims paid by the SMA for the period July 1, 2007 through September 30, 2007.
15. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
16. The Recipient ID field was 100.00% complete, accurate and valid.
17. The First Date of Service field was 100.00% complete and accurate, and valid.
18. The Last Date of Service field was 100.00% complete and accurate, and

valid.

19. The Units of Service field was 100.00% complete, accurate and valid.
20. The Outpatient Procedure Code field was 100.00% complete and accurate, and 80.73% valid. There were 11,712 entries of 60 invalid codes.
21. The Revenue Code field was 100.00% complete, accurate and valid.
22. The first Diagnosis Code field was 100.00% complete, accurate and valid.
23. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, they all fell well below the 100% threshold set by SMA for completeness, accuracy and validity. The second, third, fourth, and fifth Diagnosis Code files were 47.99%, 22.69%, 10.84%, and 0.66% respectively. The remaining fields were blank (incomplete, inaccurate, and invalid).

For the Pharmacy claim type, there were 73,775 claims paid by the SMA for the period July 1, 2007 through September 30, 2007. All fields examined were 100.00% complete, accurate and valid.

What Types of Encounter Claim Data are Missing and Why?

Based on the above analysis of the accuracy, completeness, and validity of the data in the SMA encounter claims extract file for Mercy CarePlus, an error analysis of the invalid entries was conducted for fields which were lower than the 100.00% threshold specified by the SMA. There were very few errors encountered in the critical fields examined across all claim types. The Hospital Outpatient Procedure Code field contained a large proportion of invalid entries. These invalid codes ranged from 250-990.

What is the Level of Volume and Consistency of Services?

When comparing the rate of encounter claim types per 1,000 members, Mercy CarePlus demonstrated significantly lower rates than the average for all MO

HealthNet Managed Care Health Plans for the Outpatient Hospital and Inpatient claim types. This may be a function of provider panel composition or claims administration. The possibility of incomplete data cannot be ruled out given the consistent pattern of low rates across claim types. Another possible explanation is less access to care for members, or a healthier member population.

To What Extent do the Claims in the State Encounter Claims Database Reflect the Information Documented in the Medical Record? What is the Fault/Match Rate between State Encounter Claims and Medical Records?

To examine the degree of match between the SMA encounter claims database and the medical record, 100 encounters from each MO HealthNet Managed Care Health Plan were randomly selected from Medical claim types for the period of July 1, 2007 through September 30, 2007 for medical record review. Of the 280,189 encounter claim types in the SMA extract file for July 1, 2007 through September 30, 2007, 100 encounters were randomly selected. Providers were requested to submit medical records for review. There were 94 medical records (94.0%) submitted for review. Encounters for which no documentation was submitted were unable to be validated. The match rate for procedures was 54.00%, with a fault rate of 46.0%. The match rate for diagnoses was 41.0%, with a 59.0% fault rate.

What Types of Errors Were Noted?

An error analysis of the errors found in the medical record review for procedure, diagnosis, drug name, and drug quantity was conducted. For the diagnosis code in the medical record, the reasons for diagnosis codes not matching the SMA extract file were missing (n = 50) and incorrect (n=9).

For the procedure code in the medical record, the reasons for procedure codes in the SMA extract file not being supported by documentation in the medical record were missing information (n = 42) and upcoded codes (n = 4). Examples of missing information included no code; codes listed that were not supported, or codes that did not match the procedure description.

To what extent do the MO HealthNet MCHP paid/unpaid encounter claims match the SMA paid database?

Since Mercy CarePlus included internal control numbers that matched those of the SMA, the planned analysis of comparing MO HealthNet Managed Care health plan encounter data to the SMA encounter claim extract file was performed. The SMA defined “unpaid claims” as those claims that the health plan denied for payment, unpaid claims do not include claims paid via a capitation plan.

For all claim types, the health plan only submitted claims with a status of “paid”. The EQRO matched all of these claims to the files contained in the SMA database. Thus, 100.00% of the MCP submitted encounters matched with the SMA encounter records

What Problems are there with How Files are Compiled and Submitted by the MO HealthNet Managed Care health plan?

The analysis of comparing Mercy CarePlus (MCP) encounter data to the SMA encounter claim extract file was conducted based on the file submitted by MCP that contained all claims for the selected sample of DCNs. While MCP did submit the data in the requested format (see Appendix 7) for the MO HealthNet Managed Care Members represented in the encounter claim sample selected by the EQRO for validation, there were no unpaid or denied claims submitted. There were no unmatched claims that were in the MCP encounter file and absent from the SMA data. Thus, 100.00% of the MCP submitted encounters matched with the SMA encounter records.

What are the Data Quality Issues Associated with the Processing of Encounter Data?

There are no data quality issues specific to this MO HealthNet Managed Care health plan. The data quality issue that continues to be a challenge for the

EQRO is the lack of a unique identifier to match unpaid or denied claims to claims data present in the SMA database.

CONCLUSIONS

STRENGTHS

1. All encounter data was submitted in the specified format and included internal control numbers (ICNs) which allowed the EQRO to conduct planned comparisons of the MCHP and SMA data files.
2. The critical field validation of all six claim types resulted in few fields under the SMA established threshold of 100.00% accuracy, completeness, and validity.
3. The critical fields examined for the Dental, Pharmacy and Inpatient claim types were 100.00% complete, accurate and valid.
4. The critical fields examined for Outpatient Hospital and Outpatient Medical were 100% complete and accurate.
5. Data was submitted in the requested format for encounter validation and all claim types were accessed.
6. Mercy CarePlus submitted more encounter medical records for review (n = 94) than they have during past reviews.
7. Claim Status (Paid, Denied, & Unpaid) was submitted.

AREAS FOR IMPROVEMENT

1. Mercy CarePlus has the lowest rate of access per 1,000 members in the encounter categories (Outpatient Hospital, and Inpatient claim types).
2. Mercy CarePlus did not have any Home Health claims during the period reviewed.
3. The Outpatient Hospital procedure code field was 80.73% valid. There were 11,712 entries of 60 invalid codes.
4. The health plan reported no Home Health encounter claims during the review period.

RECOMMENDATIONS

1. The health plan should examine the rate of claims per 1,000 members across claim types and the rate of rejected claims for each claim submission format (UB-92, NSF/CMS 1500, NCPDP 3.0) over time to examine the consistency in claims submission and identify issues for data submission. The access to care should also be examined as a possible reason for the lower rates of encounter claims per 1,000 members.
2. The SMA should examine and revise as needed internal system edits for invalid procedure codes in the NSF/CMS 1500 file layout and run validity checks after the programming of new edits.
3. For the Outpatient Hospital claim type, improve the rate of valid procedure codes.

10.4 MO HealthNet MCHP Compliance with Managed Care Regulations

METHODS

Prior to the site visit, documentation was received and reviewed regarding the MO HealthNet Managed Care Health Plan's compliance with the State contract. The External Quality Review Organization (EQRO) reviewed contract documents with the staff of the MO HealthNet Division (MHD). It is noted that Mercy CarePlus is in its second year of operations as a MO HealthNet Managed Care Health Plan. This health plan previously operated under the name of Community CarePlus. This action became effective with the current MO HealthNet Managed Care contract that went into operation on July 1, 2006. The new health plan, Mercy CarePlus currently has contracts to provide services in all three Regions, although their largest population remains in the Eastern Region with approximately 56,000 members. They currently report having over 5,500 members in the Central Region, which is a substantial increase over the 1000 members reported in 2006. In the Western Region the health plan now serves nearly 8000 members, which is another substantial increase over the 3000 members served in 2006. They continue to develop their emerging census in the two additional service regions. The MO HealthNet Managed Care Health Plan discussed in this report will be compared to the health plan formerly named Community CarePlus when required.

On-site review time was used to conduct interviews with Member Services' Staff and Supervisors, and separately with Case Management Staff and Supervisors. This approach was utilized to validate what practices occurred when serving members. These interactions and responses were compared to policy requirements to ensure that both are within the scope of the contract and are conducted in a manner that meets or exceeds federal regulations.

A detailed interview tool, individualized for Member Services' Staff and for Case Management staff, was utilized to ensure that all pertinent elements of the federal regulations were addressed in the interview process. Additionally, an interview tool was constructed for administrative staff to validate and clarify these practices and to follow-up on questions raised from the interviews.

Additional document reviews occurred on-site to validate any policies and procedures that were in question after discussions with the SMA, and after the review of the health plans annual report. This document review occurred prior to the on-site review.

DOCUMENT REVIEW

The following documents pertaining to Mercy CarePlus were reviewed prior to and at the on-site visit:

The Division of Medical Services supplied:

- State of Missouri Contract Compliance Tool (including DMHN responses and comments)

The following documents were requested and reviewed on-site:

- Member Handbook
- 2007 Marketing Plan and Materials
- Provider Handbook
- Policy Tracking Log
- Member and Provider Grievance and Appeal Logs
- Medical Management Policy and Training Requirements
- Credentialing Policies
- Case Management Policy

Additional documentation made available by Mercy CarePlus included:

- Organizational Chart
- Access Standards and Compliance Policy
- Quality Improvement Committee Meeting Minutes
- MCP Welcome Packets, with correspondence, postcards, privacy/HIPPA information

- 2006 Quality Monitoring Log

The medical management and credentialing policy reviewed indicates that Mercy CarePlus is following NCQA Standards. All of these policies have been submitted to the SMA for their final approval. It was detailed and appeared to comply with federal regulations. Quality Improvement Committee Meeting Minutes were also reviewed. They contained reports of monthly activities which related to the actual goals of the health plan.

Documents reviewed indicated that the health plan is moving toward NCQA accreditation and indicated a significant change in quality focus. The health plan was purchased by Molina Healthcare in November 2007. No changes in name or operations occurred during 2007. It is noted here as a number of documents reviewed reflected the Molina Healthcare name and format.

INTERVIEWS

Interviews were conducted with the following groups:

Plan Administration

- Zarina Sparling– Interim CEO
- Robert Profumo, MD – Chief Medical Officer
- Nancy Zmuda – Director, Utilization Management
- Steve Mead – Director, Compliance and Regulatory Affairs
- Tracy Hay – Director, Member Services
- Jennifer Goedeke – Director, Quality Improvement
- Robin Woolfolk – Director, Customer Service
- Jodi Giordano – Director, Provider Contracts

Member Services Staff



- Jacqueline McCarter – Lead Member Services Representative
- Robin Woolfolk – Manager, Member Services
- LaShonda Kahill – Member Services, Quality Auditor
- Tracy Hay – Director, Member Services
- Jennifer Goedke – Director, Quality Improvement
- Steve Mead – Director, Compliance and Regulatory Affairs

Case Manager Staff

- Cherie Brown – Manager, Case Management/Prior Authorization
- April Gross – Complex Case Manager I
- Diane Jellison – Complex Case Manager I
- Nancy Zmuda – Director, Utilization Management
- Mary Luley – Manager, Utilization Management
- Jennifer Goedeke – Director, Quality Improvement
- Dr. Robert Profumo – Chief Medical Officer

FINDINGS

ENROLLEE RIGHTS AND PROTECTIONS

Mercy CarePlus continued their efforts to track and monitor all policy required to be submitted to and reviewed by the SMA. This included policy and procedures for initial and annual approval, as well as marketing materials. Additionally, the MCHP developed an inventory of all written materials or purchased materials that must be approved by the SMA prior to being shared with members. A binder including all Annual Marketing Materials and the annual marketing plan was compiled and shared during the on-site review.

The Member Handbook was approved by the SMA and continues to be recorded in a format to be shared with members who are visually impaired or have other challenges with written material. Certified interpreters for deaf or non-English speaking members are provided as needed. The International Institute and the Language Access Metro Project (LAMP) are the primary resources used for interpretive services by Mercy CarePlus. The MCHP reports receiving a number of calls every month that required interpretive services, these calls have been handled in a routine manner. They do report there have been no new language requests in the past year.

Training is regularly provided to ensure that the Mercy CarePlus Call Center staff is knowledgeable about members' rights and responsibilities. Training sessions were held on two State holidays, when there are normally fewer calls. These training sessions focused on customer services and medical management with a focus on members' rights and responsibilities. All incoming calls are monitored and additional in-service training and coaching is provided based on information gathered. Previously, Call Center staff rotated to provide 24-hour coverage on holidays and weekends. Currently the MCHP contracts with Team Health, a nurse advice line service, for after-hour coverage. This service is available twenty-four (24) hours, seven (7) days per week. The Call Center staff also assists in contacting new members.

Member Services staff exhibit a strong degree of advocacy in providing services to health plan members. They make every effort to support new members with information and assistance. Member Services staff provides names, geographic locations and availability of providers and other supportive health care services. They encourage members to ask questions and provide answers, or obtain necessary information for other sections of the health plan to adequately respond to the member. Staff reports that they always attempt to go through the Member Handbook with the new health plan members to ensure familiarity with all the sections and the information provided. They also inform health plan members about the health plan website. This staff reports that health plan members are using the website in increasing numbers.

Mercy CarePlus continues to enhance case management services to members with special needs. They review all sources to identify members in need of case management, and provide them with individual attention as quickly as possible. Case managers provide direct services and track all pregnant members. Pregnant members receive varying levels of case management services, based

on an assessed level of risk. The members with a moderate or high level of risk received enhanced case management throughout their pregnancy and post partum term with the goal of reducing the number of low birth weight babies. The rate of Obstetrical Case Management has increased across all three Regions. The health plan has tracked statistics indicating that babies born at 28 to 36 weeks are living, which has increased the number of newborn inpatient days in the hospital. Members, with other healthcare issues, that are targeted for case management include those who have high blood lead levels, have identified special healthcare needs, and any catastrophic illness. They currently have three case management coordinators who assist members in obtaining services after-hours.

The MCHP now uses a web-based case management system. This system assists in making objective and balanced decisions on services available, such as durable medical equipment. This system is being implemented incrementally. They currently have access to the case review process and have the capability of generating letters to members. The Lead Case Manager maintains a database with information provided by the SMA, and is active in educating providers regarding the use of capillary testing to encourage blood lead level tests for children. This information will be in the new case management system in the near future. The health plan's Medical Director meets with case management staff to discuss cases and holds weekly case conferences. This type of support was beneficial to the health plan and to case management activities. The case management staff conducts outreach to hospitals.

Case Managers reported receiving referrals from a variety of sources. These include Member Services staff, Pre-authorization staff, providers, the SMA system, concurrent review nurses and behavioral health case managers. They gave an example of receiving a referral from pre-authorization nurses for a member requesting home health services. This member was not receiving case management, but was immediately referred. The health plan case managers also review claims data, patient notes, pharmacy data and the 24-hour nurse line lists to ensure that all necessary referrals are received. The case managers did discuss that members have the right to accept or refuse both case management and any medical treatment offered. They make every effort to ensure that members had access to special services and required medical treatment. They could also provide examples of the methods they utilize to ensure that members are aware of their right to have an impact on treatment planning. These staff exhibit a clear commitment to the members they serve.

The rating for Enrollee Rights and Protections (100.0%), which is a significant increase over the 2006 rate (53.8%), indicates that Mercy CarePlus has made a

concerted and successful effort to have written policies and procedures submitted to and approved by the SMA. It is to be noted that the health plan made improvement in this area, has improved tracking and internal processes, and is in the process of completing policy development and submission each year, which has now resulted in the current rating. Mercy CarePlus exhibited a businesslike approach and commitment to continue their efforts to improve in the completion and submission of required policies and procedures. Their 2006 stated goal was to become fully compliant with all MO HealthNet Managed Care contract requirements and federal regulations. The outcome of this review is evidence of their efforts in this regard.

Table 75 – Subpart C: Enrollee Rights and Protections Yearly Comparison (MCP)

Federal Regulation	MCP		
	2005	2006	2007
438.100(a) Enrollee Rights: General Rule	2	1	2
438.10(b) Enrollee Rights: Information Requirements	1	1	2
438.10(c)(3) Alternative Language: Prevalent Language	2	2	2
438.10(c)(4,5) Language and Format: Interpreter Services	1	2	2
438.10(d)(1)(i) Information Requirements: Format/Easily Understood	2	1	2
438.10(d)(1)(ii) and (2) Information Requirements: Format Visually Impaired, and Limited Reading Proficiency	1	1	2
438.10(f) Information for All Enrollees: Free Choice, etc.	1	2	2
438.10 (g) Information to Enrollees: Specifics/Physician Incentive Plans	2	2	2
438.10(i) Special Rules: Liability for Payment/Cost Sharing	1	2	2
438.100(b)(2)(iii) Enrollee Rights: Provider-Enrollee Communications	2	1	2
438.100(b)(2)(iv,v) Rights to Refuse Services/Advance Directives	1	2	2
438.100(b)(3) Right to Services	1	1	2
438.100(d) Compliance with Other Federal/State Laws	2	2	2
Number Met	6	7	13
Number Partially Met	7	6	0
Number Not Met	0	0	0
Rate Met	46.2%	53.8%	100.0%

Note: 0 = Not Met; 1= Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols.

BEHAVIORAL HEALTH

MHNet is the Behavioral Health Organization (BHO) that subcontracts with Mercy CarePlus for mental and behavioral health services for members. This was the first full year of operation for this BHO at Mercy CarePlus. The health plan reported a smooth transition and no specific problems occurring in terms of members accessing services during the 2007 program year. The BHO makes an effort to assist members in obtaining timely access to services. Members are encouraged to contact the BHO to make appointments, particularly if they have contacted providers directly without success. Providers are listed on their website in an effort to ensure that members have this information. Adequate providers have been enlisted in both the Central and Western Regions to meet service needs in these areas. The BHO has made an effort to improve coordination between behavioral health providers and the member's primary care physician. They are committed to continuing improvement in this area.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

Access Standards

Mercy CarePlus continues to make improvements in the area of access standards during 2007. The health plan had a schedule to submit policies and procedures to the SMA for annual review as required. The health plan explained that currently all authorizations were received from providers telephonically. Mercy CarePlus staff measured the requests and accompanying information against InterQual criteria. If the decision was to deny the authorization, the information was reviewed by the medical director prior to entry into the health plan's system. All authorizations were tracked and monitored. The health plan required prior authorization of all inpatient stays, MRI, CT scan, physical therapy, occupational therapy, speech therapy, certain medications, home health

services and pain management. Mercy CarePlus made it clear that there is a system in place to pay for emergency services regardless of who provides them. Policy in this area and addressing the method for covering post-stabilization services has been rewritten and submitted to the SMA for approval.

Mercy CarePlus decreased the timeframes for responding to authorization requests. They updated their policy to ensure that denials would be overturned when adequate information was provided. Tracking and trending of information occurred and is reviewed on a monthly basis.

Member Services reports receiving 15-20 calls per day regarding closed panels. The health plan has implemented a number of strategies to cope with this problem. Most providers agree to see siblings of children who are already members or patients. Assignments are done with the consultation of the member whenever possible. If auto assignments are required, distance is the main consideration. Direct contact with physicians to assist members with appointments is made whenever necessary. The health plan reports that adding several hospitals and physician groups not previously available during 2006 has assisted in adequately serving members in the Eastern Region. Mercy CarePlus reported that although several large hospitals were not in their network, they maintained a strong relationship with those systems and would create out-of-network agreements for members if the need arose.

Mercy CarePlus reported that they continue to struggle with finding several specialty providers, particularly pediatric neurologists, rheumatologists, and orthopedic surgeons. The health plan has been able to negotiate for these services because the Provider Relations staff developed individualized relationships with providers. They did report paying orthopedic surgeons 100% of billed charges.

Mercy CarePlus assessed provider availability annually when producing their report to the Missouri Department of Insurance, Financial Institutions and Professional Registration (MDIFP). In 2006 the MCHP reviewed the availability of 24-hour coverage by providers, as required in their MO HealthNet Managed Care Contract. The MCHP monitored provider telephone logs, conducted blind telephone testing, and obtained input from providers directly. Mercy CarePlus reported a large degree of success in this area, but admitted that there were providers who needed work. During 2007 the health plan has continued follow-up efforts with providers to ensure that timely and adequate health care service delivery improved. The health plan continues provider education and testing in this area. The health plan reported that they contracted with all of the Federally Qualified Health Centers (FQHCs) in the three regions. This effort improved daytime and some after-hours access.

Member Services staff were asked about service availability. They gave examples of providing members with information about all services available, and the location of urgent care centers and physicians who have after-hours clinics. They also gave examples of directly contacting providers to ensure that members obtained timely appointments, to clarify information, and to locate specialists. The Member Services staff also contacts the Provider Relations staff to relay issues for follow-up contacts, clarification, or problem resolution.

Member Services staff also described activities within the health plan to obtain information and feedback from members, such as return telephone contacts and surveys. They utilize this information to improve customer service and to assess member satisfaction. The Member Services staff reports that they have learned how to listen to members and identify if a family member has special needs. They immediately refer these members for case management and more in-depth services. The referral and need for information is recorded in the health plan system to all involved staff members are aware of the member's needs and

follow-up contact.

Case Managers discussed their efforts to ensure that members have access to all the services they require, specifically for members with special health care needs. They encourage members to utilize the nurse help line and educate them on all health care resources that are available. The case managers contact providers, review utilization, and participate in treatment planning to ensure that members have access to all required health care services. The case managers report that members do not currently receive a written copy of their treatment plan. However, their new case management system will generate letters that include the treatment plan so members will have this in a written form. The case managers explained that the member supplies the information necessary to develop the treatment plan, and the case manager ensures that there are no gaps in providing effective treatment. Coordination of services, with medical providers, and with behavioral health services is an essential component of their case management process.

Ratings for compliance with Access Standards (100.0%) reflect a serious attempt by the health plan to complete required policy to meet the requirements of the MO HealthNet Managed Care contract and federal regulations. This rating is an improvement over 2006 (88.2%). This is the first year that all required policy and procedure are complete. Mercy CarePlus will continue their efforts to develop necessary policy and practice to be in full compliance. Observations made at the time of the on-site review indicated that these efforts were continuing and full compliance was an ongoing health plan goal.

Member Services added two Spanish speaking and one Bosnian speaking staff members when the Central and Western Regions were added to their contract. They also have one staff member who speaks four (4) languages including German. The health plan believes they have adequate diversity and provides

members enough alternatives to be comfortable when contact is made.

Table 76 – Subpart D: Quality Assessment and Performance Improvement: Access Standards Yearly Comparison (MCP)

Federal Regulation	MCP		
	2005	2006	2007
438.206(b)(1)(i-v) Availability of Services: Provider Network	2	2	2
438.206 (b) (2) Access to Well Woman Care: Direct Access	1	2	2
438.206(b)(3) Second Opinions	2	2	2
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	1	2	2
438.206(b)(5) Out of Network Services: Cost Sharing	1	1	2
438.206(c)(1)(i-vi) Timely Access	1	2	2
438.206(c)(2) Provider Services: Cultural Competency	2	2	2
438.208(b) Care Coordination: Primary Care	1	2	2
438.208(c)(1) Care Coordination: Identification	2	2	2
438.208(c)(2) Care Coordination: Assessment	1	2	2
438.208(c)(3) Care Coordination: Treatment Plans	1	2	2
438.208(c)(4) Care Coordination: Direct Access to Specialists	1	2	2
438.210(b) Authorization of Services	2	2	2
438.210(c) Notice of Adverse Action	2	2	2
438.210(d) Timeframes for Decisions, Expedited Authorizations	2	2	2
438.210(e) Compensation of Utilization Management Activities	2	2	2
438.114 Emergency and Post-Stabilization Services	1	1	2
Number Met	8	15	17
Number Partially Met	9	2	0
Number Not Met	0	0	0
Rate Met	47.1%	88.2%	100.0%

Note: 0 = Not Met; 1 = Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols.

Structures and Operation Standards

Mercy CarePlus continued to develop their credentialing standards. The health plan assured that all providers maintained licensure and the right to practice in Missouri. Source One was employed to run a monthly data scan against licensing listings. This process enabled the health plan to maintain current

licensure information. Mercy CarePlus reported that they were current on all credentialing for new physicians and on delegated credentialing. The health plan developed a work plan to ensure that the remaining provider list would be current during the coming year. The health plan reported that they are current on all providers due for credentialing. Delegated credentialing is granted to the SSM hospital system and to the BHO MHNet. Certification of the delegated credentialing is completed by Source One.

During 2006 an after-hours survey was conducted that indicated problems in several areas. One of these was telephone access to twenty-four hour primary care physician (PCP) availability. During 2007 Mercy CarePlus worked toward making after-hours services available to prevent the unnecessary use of emergency rooms. The health plan provided education to members on the use of the Team Health Nurse Advice Line, and contacted PCPs directly if problems were not resolved. Provider representatives visited these PCP offices every six weeks for follow-up, and provided additional assistance to trouble shoot specific issues. Mercy CarePlus developed an oversight tool for this purpose.

Mercy CarePlus has instituted a more rigorous approach to training to ensure that staff is aware of new policies and procedures. This has led to improved services and improved interdepartmental communications.

Member Services staff report being aware of the policies and procedures to utilize if a health plan member calls and requests disenrollment. They do ask questions to ensure that the call is not the result of an issue that can be resolved, or referred on as a grievance or appeal. When the member is adamant, the process for disenrollment is started immediately. This does not occur with any regularity, but they state that they attempt to be as helpful and accommodating as possible. If the member calls regarding the need for an authorization, or any other activity that should occur immediately, Member

Services obtain as much information as possible, and then make the appropriate referral for the member. This referral may be to case management, utilization management, or the grievance and appeals unit. The staff members interviewed gave examples that make it clear that they understand these processes and that they act in the members' behalf.

In addition to care coordination, case managers discussed the use of practice guidelines and other information used to ensure that special issues are addressed in serving members. The Case Management staff works with the Utilization Review section and with the concurrent review nurses to ensure that all members receive the health care services needed.

The rating for Structure and Operation Standards (100%) reflects the timely and efficient submission of policy to the SMA for their review and approval. This is an improvement over to 2006 rating (80%). The MCHP understood that continued efforts in this area of practice will be needed. Their progress in this area of compliance is noteworthy. Observations at the time of the on-site review support Mercy CarePlus's success at identifying and improving areas that had previously been problematic.

Table 77 – Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison (MCP)

Federal Regulation	MCP		
	2005	2006	2007
438.214(a,b) Provider Selection: Credentialing/Recertification	1	1	2
438.214(c) and 438.12 Provider Selection: Nondiscrimination	2	2	2
438.214(d) Provider Selection: Excluded Providers	1	2	2
438.214(e) Provider Selection: State Requirements	2	2	2
438.226 and 438.56(b)(1-3) Disenrollment: Requirements and limitations	1	1	2
438.56(c) Disenrollment Requested by the Enrollee	2	2	2
438.56(d) Disenrollment: Procedures	2	2	2
438.56(e) Disenrollment: Timeframes	1	2	2
438.228 Grievance System	1	2	2
438.230(a,b) Subcontractual Relationships and Delegation	1	2	2

Number Met	4	8	10
Number Partially Met	6	2	0
Number Not Met	0	0	0
Rate Met	40.0%	80.0%	100%

Note: 0 = Not Met; 1= Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols.

Measurement and Improvement

Mercy CarePlus has developed and implemented specific practice guidelines with providers at the time of the 2007 review. The health plan has now instituted the National Heart, Lung, and Blood Guidelines for asthma care for adults and children. NIH clinical guidelines and Kansas City guidelines were adopted for several other areas of healthcare delivery. This information and methods to utilize these guidelines have been distributed to all health plan providers.

Mercy CarePlus instituted a number of Quality Assessment and Performance Improvement activities during 2007. Their Quality Improvement group meets quarterly and includes local physicians who actively participated. The health plan's goal of providing quality services to members was the focus of the group's discussions. Mercy CarePlus viewed this initiative as having a positive effect on the performance and focus of the MCHP. The QA & I group is currently looking at tracking and trending the health plan system to ensure member access in a timely and efficient manner. The health plan hopes to use this information to ensure that all members have adequate access to those services.

Mercy CarePlus worked with the Missouri Department of Health and Senior Services (DHSS) to obtain historical immunization information since November 2004. They continue to use the MOSAIC system to obtain lead and immunization statistics.

Mercy CarePlus reported that the Quality Assessment and Improvement

program was involved in the development of policy regarding member Grievance and Appeals, and provider Complaints, Grievances and Appeals. The health plan set up an internal monitoring process and found a continued success in sending letters according to policy throughout 2006. This success has also continued throughout 2007.

Mercy CarePlus submitted two Performance Improvement Projects (PIPs) for validation. Although these PIPs lacked complete maturity to allow for validation, they indicated substantial improvement in utilization of this process as a tool for MCHP growth. The structure of both PIPs followed the federal protocol and showed a great deal of potential. These PIPs indicated an increased degree of understanding of the importance of the PIP process in improving health plan operations and health care services to members.

This section does not directly apply to the Member Services and Case Management staff. However, both report that members often asked relevant questions about issues that are covered by practice guidelines. The case managers gave one example of a member, who is a registered nurse, asking for the asthma practice guidelines. She related that she was not sure her child was being treated properly and wanted to discuss this with the physician. This information was supplied to the member prior to their appointment.

The MCHP submitted all required information to complete the Validation of Performance Measures for all three measures, as requested. The specific outcomes of the Performance Measure outcomes are discussed in the appropriate section of this report. Mercy CarePlus continued to operate a health information system within the guidelines of that protocol. All encounter data requested was provided in the correct format. The complete details of each of these areas of validation can be reviewed within specific sections of this report.

The rating for Measurement and Improvement (100%) reflects a continued diligence toward meeting the requirements of the MO HealthNet Managed Care contract and federal regulations. These policies and procedures have all been submitted to and approved by the SMA.

Table 78 – Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement Yearly Comparison (MCP)

Federal Regulation	MCP		
	2005	2006	2007
438.236(b)(1-4) Practice Guidelines: Adoption	1	2	2
438.236(c) Practice Guidelines: Dissemination	1	2	2
438.236(d) Practice Guidelines: Application	1	2	2
438.240(a)(1) QAPI: General Rules	1	2	2
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCHP Quality Improvement and PIPs	1	2	2
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	2	2	2
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	2	2	2
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	2	2	2
438.240(e) QAPI: Program Review by State	NA	NA	NA
438.242(a) Health Information Systems	2	2	2
438.242(b)(1,2) Health Information Systems: Basic Elements	2	2	2
438.242(b)(3) Health Information Systems: Basic Elements	2	2	2
Number Met	6	11	11
Number Partially Met	5	0	0
Number Not Met	0	0	0
Rate Met	54.5%	100.0%	100%

Note: Regulation 438.240(e) refers to program review by the state. The regulation requires the state to review, at least annually, the impact and effectiveness of each MCHP's quality assessment and performance improvement program. The regulation refers to the state QA & I program review process and is not applicable to External Quality Review of the MC+ Managed Care Program. This percent is calculated for the regulations that are applicable to the MC+ Managed Care Program. 0 = Not Met; 1 = Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOPs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols.

Grievance Systems

Mercy CarePlus completed and submitted all required policy and procedures to make their Grievance System compliant with MO HealthNet Managed Care contract requirements and federal regulations. The health plan put processes in place to capture member and provider contacts. The health plan continues to report that they are working smarter and have developed better communication between internal departments. This enhanced their ability to track and respond to member grievance and appeals, as well as provider complaints, grievances, and appeals. To accomplish the additional

responsibilities in the area of response to member grievance and appeals, and provider complaints grievances and appeals, Mercy CarePlus has three coordinators in place. The additional staff added in the past year has assisted in obtaining success for this portion of this program. The health plan developed an on-line tracking system that contributes to timely responses in the complaint, grievance and appeal process.

Member Services staff reports that they receive many calls regarding member concerns. They request a brief overview of the issue, record pertinent information in their tracking system, and immediately refer the issue to the Grievance and Appeals Coordinator. They relate that this coordinator then contact the member and discusses the grievance and appeals process with the member, and assist the member in negotiating the system. The Member Services staff is aware of the State Fair Hearing process and has only received a few requests for a State Fair Hearing. They reported that in the past year two formal requests were received by the Grievance and Appeals Coordinator and four were received by the Health Plan Administrator. They were handled according to approved policy. Tracking occurs with the Grievance and Appeals Coordinator, and is reviewed by the Quality Assessment and Improvement Committee. Corrective action within the health plan occurs as necessary as the result of review of the grievances and appeals received. If the situation concerns a provider, a corrective action plan is put in place and appropriate monitoring occurs.

Case Managers were aware of the health plan's grievance and appeals process. They related that they are often contacted when an authorization is denied and the member receives this information in writing. They then coach the member about the process and on further available actions. They also attempt to provide an explanation of the decision. The case managers advocate for the members through this process, including directly contacting the Medical Director for further input and assistance in the decision review. The

case managers report that they do receive information for the Grievance and Appeal Coordinator about the outcomes, and further action required by the health plan members they serve.

Mercy CarePlus has worked diligently to improve their internal processes and practices to establish a system that is efficient and responsive to both members and providers. At the time of the on-site review, the current Grievance System, policy, and information tracking all appeared to be working efficiently. It appears that significant improvement has occurred in their processes.

The rating for the Grievance System (100%) reflects approval of the majority of policy and procedures required to meet MO HealthNet Managed Care contract requirements and federal policy. Practices observed at the time of the on-site review indicated that Mercy CarePlus was meeting all requirements of operating a functional Grievance System for both providers and members.

Table 79 – Subpart F: Grievance Systems Yearly Comparison (MCP)

Federal Regulation	MCP		
	2005	2006	2007
438.402(a) Grievance and Appeals: General Requirements	2	2	2
438.402(b)(1) Grievance System: Filing Requirements - Authority	2	2	2
438.402(b)(2) Grievance System: Filing Requirements - Timing	2	2	2
438.402(b)(3) Grievance System: Filing Requirements - Procedures	2	2	2
438.404(a) Grievance System: Notice of Action - Language and Format	2	2	2
438.404(b) Notice of Action: Content	2	2	2
438.404(c) Notice of Action: Timing	2	2	2
438.406(a) Handling of Grievances and Appeals: General Requirements	2	2	2
438.406(b) Handling of Grievance and Appeals: Special Requirements for Appeals	2	2	2
438.408(a) Resolution and Notification: Basic Rule	2	2	2
438.408(b,c) Resolution and Notification: Grievances and Appeals - Timeframes and Extensions	2	2	2
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	2	2	2
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	2	2	2
438.410 Expedited Resolution of Appeals	2	2	2
438.414 Information about the Grievance System to Providers and Subcontractors	2	2	2
438.416 Recordkeeping and Reporting Requirements	1	2	2
438.420 Continuation of Benefits while Appeal/Fair Hearing Pends	2	2	2
438.424 Effectuation of Reversed Appeal Resolutions	2	2	2
Number Met	17	18	18
Number Partially Met	1	0	0
Number Not Met	0	0	0
Rate Met	94.4%	100.0%	100.0%

Note: 0 = Not Met; 1= Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols

CONCLUSIONS

Mercy CarePlus was 100% compliant in all areas for the first time since the EQR process was initiated. It is noted that the health plan has made significant improvement in policy and procedure submission and approval in all areas. At the time of this review improvement in many areas of performance were observed. Mercy CarePlus continues their commitment to members and to providing healthcare services in an effective manner by demonstrating an atmosphere of respect and dignity toward members. The health plan's efforts to be fully compliant in both having approved policy and verifiable approved practice is evidence of the efforts made during the past year. These improvements provided a sound foundation for continued efforts to make the changes required to maintain full compliance in the future.

QUALITY OF CARE

During the previous on-site review Mercy CarePlus indicated that they recognized the need to improve in the development of policies and procedures, and continue to review and upgrade their organization's performance. They exhibited the outcomes of the commitment to these goals, and provided sound examples of the progress made during 2007. These discussions took place in the context of providing quality care and services to members. The health plan exhibits a distinct recognition of the importance within the organization of the need for clear communication between departments to effectively meet members' service needs. Quality services at the health plan and provider levels were evident in the information presented. It should also be noted that this health plan maintains a system of regular direct contact with providers. Provider relations staff make regular in-person visits, at approximately six week intervals, to provider offices. This enhances the quality of relationships between the health plan and their providers, enabling them to troubleshoot, educate, and ensure that members receive the healthcare services they require. It is also recognized

that the health plan staff that have the greatest direct contact with health plan members, Member Services and Case Management, are integrally aware of how their departments interact with and are supported by the other departments within the health plan structure. This enhances the staffs' ability to serve members in an efficient and quality manner.

ACCESS TO CARE

Mercy CarePlus did make a number of changes during the past two years to improve access to care for members. They were able to contract with a number of hospitals that were previously not in their network. Their provider panel has expanded in the availability of primary care physicians and specialists. The health plan instituted a method of contacting primary care physicians for members when members experience problems obtaining appointments. All of these activities, as well as improvements and training for Member Services staff, and additions in resources for Case Managers have created an atmosphere where assuring access to care is an essential aspect of the Mercy CarePlus program.

TIMELINESS OF CARE

An attention to the issue of timeliness of care was also evident at the health plan. They have improved significantly in the area of timely and complete policy submission. Changes and improvements of internal processes have also made timely response to member and provider issues a priority. Timeliness of healthcare improved as the result of changes and expansions within the organization. Both Case Managers and Member Services staff report that timely and adequate health care services are of primary importance in their involvement with health plan members. These staff gave concrete examples of making direct contact with providers to ensure that appointment and services were delivered in a timely manner to illustrate this as an essential value supported by Mercy CarePlus.

RECOMMENDATIONS

1. Continue to develop the atmosphere within Mercy CarePlus that motivates the attention to compliance with contractual requirements and federal regulations. A great deal of improvement was witnessed in this area.

Maintaining these improvements is an important factor in establishing continued confidence in the health plan.

2. Continue to utilize the resources at Mercy CarePlus to complete all necessary policy documentation and submission to the SMA.
3. Continue to enhance the area of quality improvement initiatives internally within the organization to ensure that quality services occur for members.
4. Continue to support front line staff in their efforts to be primary advocates for members and to provide an atmosphere based on the desire to excellent healthcare services to members.
5. Continue to utilize available data and member information in order to drive, change, and measure performance.

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11.0 Missouri Care

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11.1 Performance Improvement Projects

METHODS

DOCUMENT REVIEW

Missouri Care supplied the following documentation for review:

- 2007 Increase Use of Controller Medications for Members with Persistent Asthma
- 2007 Seven-Day Follow-Up After Hospitalization for Mental Illness

INTERVIEWS

Interviews were conducted with the project leaders for each Performance Improvement Project (PIP) by the EQRO team on July 16, 2008 during the on-site review in the offices in Columbia, Missouri, and included the following:

Tammy Weise – Manager, Quality Management
Dr. Andrew Matera – Chief Medical Officer
Brent Netemeyer – Manager, Operations
Katie Dunne – Senior Quality Coordinator

The interviewees shared information on the validation methods, study design, and findings. Technical assistance regarding study design and presentation of findings were provided by the EQRO. The following questions were addressed:

- Who were the staff involved in this project and what were their roles?
- How were the topics identified? Expand on why they are important to the health plan and its members.
- Discuss the findings and how they were interpreted.
- How were the interventions determined and why did the health plan choose this approach?
- Are these studies ongoing?
- Discuss the effects of these interventions and how they impacted services to members.
- What does Missouri Care want to study or learn from their PIPs?

Both of the PIPs submitted for validation were of adequate maturity to allow for a thorough evaluation. However, the health plan was instructed during the site visit that they could submit additional information that included updates to the outcomes of the interventions or additional data analysis. Additional information was received for the PIP.

FINDINGS

The first PIP evaluated was, "Increase Use of Controller Medications for Members with Persistent Asthma." This PIP was identified as a clinical project. This PIP was designed to target improvement in a relevant area of member care. The rationale for the topic study choice was well documented in the information presented. The topic was justified in terms of providing sound local and national literature and research supporting the assertion that it would improve health outcomes for MO HealthNet Managed Care members. It included information on the population and provided a strong argument for choosing the topic for a performance improvement project. The overarching goal of the project was clearly focused on correcting deficiencies in health care services. To accomplish this goal the PIP project planned to work with primary care providers to ensure that members had access to appropriate controller medications, which could decrease the need for more invasive medical interventions.

The study question presented was, "Will mailing primary care providers quarterly rosters of their assigned members who have persistent asthma, but who are not on controller medications, increase the rate of members being dispensed the appropriate medications?" The presentation of the study questions provided an understanding of the basis of the study and planned interventions. The question and supporting information provided confidence in the proposed methodology and anticipated outcomes. The wording of the question

continued to limit the PIP in entertaining new or expanded interventions for future work on this subject.

The definitions of each indicator were linked to the study question and were based on specific HEDIS measures defining goals for this project. The objectives were clearly identified and well-defined. The indicators were set up to improve treatment of members with persistent asthma. The health plan did define their population based on HEDIS technical specifications. Any member over two years of age is eligible, unless their diagnosis included emphysema or COPD. The PIP included a rationale for excluding these members. These members were not excluded to prevent delivery of additional services to those with special health care needs.

The study design clearly identified the data to be collected and the sources of this data. The study design specified the use of the HEDIS technical specifications as the method for collecting data for both the HEDIS measure information and the HEDIS-like data. The query rules were included. The original information submitted prior to the on-site review was difficult to understand and required a more detailed explanation. The update received after the on-site review provided the details of how the HEDIS-like data was pulled, and how they ensured that consistency is an essential component of their measurement techniques and interpretations. Time frames for collection and analysis were provided in enough detail to give confidence in the methodology used. An assumption can be made, as a result of the original and updated information included, that the health plan will collect data in a consistent and accurate manner. The documentation provided adequate narrative to determine that consistency and accuracy will be achieved.

A prospective data analysis plan was described in detail, including all planned analysis and a prospective look at the definition of success of the intervention. The plan includes the methodology for obtaining a 95% confidence level in all data obtained and evaluated. Information on staff involved, their roles, and qualifications was not originally included in any detail. In the updated information a detailed description was included of each member of the PIP team, their roles, and their qualifications.

The planned interventions were described in enough detail to ensure a thorough understanding of the rationale presented, and to create confidence in the expected outcomes to be achieved by this study. The enhanced narrative did lack discussion regarding the barriers that may be experienced in complying with physician orders, and other variables that may impact member behavior. The study narrative did include a baseline data measurement and results for the first re-measurement phase of the project. Additional results for the third year

were provided. These results indicated a significant increase compared to the baseline statistics. The results in most cases did not reach the benchmark set by HEDIS in 2006, but the 2007 rates achieved surpassed the HEDSI 2007 rates. All of this information is based on acceptable HEDIS rates for the measures involved. The data included did provide confidence that the interventions being employed were having a positive impact of the quality of care received by members. The narrative states that “to date this performance improvement project has proven to be an effective means to improving the rate of members with persistent asthma who receive a controller medication.” The data provided and all information included does support this assertion. The health plan plans to continue these educational efforts, and other interventions that are designed to improve outcomes for members with asthma indicators. The updated submission verifies sustained statistical increases in the rates achieved. Due to this improved performance the health plan is incorporating the PIP activities into routine plan practices.

The second PIP evaluated was “Post Mental Health Hospitalization Follow-Up Care within Seven Days of Discharge.” This is a non-clinical study. The study topic was chosen to improve the rate of outpatient follow-up care after hospitalization for mental illness. The health plan used their current HEDIS performance rates compared to the NCQA benchmarks and MO HealthNet’s required reporting on this measure as an additional justification to initiate a performance improvement project. The documentation presented a thorough discussion of the rationale for selecting this study topic including a literature review of information from both local and national sources. The health plan initiated this performance improvement project in 2005 to implement case and care management activities to increase compliance with recommended outpatient treatment following hospitalization for mental health treatment for their members. They expanded this PIP in January 2006 to increase the rate of follow-up appointments within seven days of discharge in an increased effort to ensure that members

obtain necessary outpatient follow up care. The information provided supporting the selection of this topic included a literature review and a sound argument for implementing this project. The interventions planned were open to all members who required hospitalization for a mental health related issue, who were six years of age and older. No members were excluded based on having special healthcare needs.

The study question presented was “Does the implementation of case management and care management activities increase the percentage of members who receive an aftercare appointment within seven (7) days of discharge from a mental health hospitalization stay?” The study question was well constructed and did not limit future expansion of the PIP if additional interventions become necessary.

The study used well operationalized indicators based on the requirements of the HEDIS measures. The indicators were clearly tied to the issues addressed in this study. The methods prescribed to track and enumerate these measures were included in the narrative provided. These indicators did measure specific outcomes that identified improved healthcare for the members. The information provided in the narrative supported the assertion that increased aftercare would lead to stronger wellness outcomes for members with mental health issues. Data sources clearly identified all members who were to be included in the study. Exclusions included children under age six (6), members discharged to an inpatient treatment facility including those specific to alcohol or drug treatment, and children in foster care, who do not receive outpatient mental health services through the health plan. All MO HealthNet Members, within the definitions of the targeted groups, were included.

The data collection approach was well planned to capture all required information to identify and provide required services to the members who were part of the study population. The narrative clearly described how data would be collected and analyzed. The study described the process the health plan will utilize to extract data monthly. They will use HEDIS data obtained yearly through an NCQA certified vendor. Administrative data will be included from the health plan's QMAC system. Discharge information is gathered from the health plan's case management system, with follow-up information obtained directly from providers. The narrative included enough specificity to ensure confidence that this process was thorough and complete. A prospective data analysis plan was presented. It included a plan for ensuring that attention to all issues were addressed, and also explained the service methodology to be employed. It outlined a plan to compare subsequent year's data to the 2006 baseline statistics. Statistical calculations to produce the 95% confidence level calculated in the HEDIS methodology will be used to monitor the ongoing process. All data sources were clearly defined and the prospective data

analysis plan was followed. The updated documentation did provide details about the staff who are involved in this project, their roles, and qualifications.

There were specific interventions identified in the narrative. How these interventions were related to the topic and study question was evident. The primary interventions described focused on contact with discharge planners and members and facilitating communication on follow-up care. Each member discharged from hospitalization, as the result of a mental health disorder is contacted by the Behavioral Health Case Manager. Appointment information is verified and the need for transportation assistance is assessed. Case management assistance is provided if the prescheduled appointment will not be attainable for the member. Additional follow-up with the provider occurs to ensure that appointment compliance occurred. Additional contact occurs to reschedule if necessary.

Data analysis was not complete at the time of the review, although it did include 2006 the baseline year and 2007 data, which was first measurement year. The results were presented numerically and were explained in the narrative provided. Confidence intervals and planning for identification of “real” improvement is part of the PIP documentation provided. The plan for subsequent year comparisons was provided. Additional information provided following the on-site review indicates that preliminary monthly data shows a significant increase from the 2006 rates.

This PIP was well-constructed. It has matured to a level where a detailed evaluation can occur. The data evaluated provided a high potential for positive performance improvement. The plan included information on additional strategies for the 2008 measurement year. The analysis was planned and the documentation provided confidence that continued efforts on this project will be completed as described. The information provided included additional

statistics for thirty (30) day follow-up even though this was not an original part of the study. The format and presentation led to ease in evaluating the project. Information was clear, organized, and understandable, all adding to the confidence in the potential outcomes. This project provides an excellent example of constructing and tracking performance improvements in making a significant change in organizational operations in an effort to improve member services and outcomes.



CONCLUSIONS

QUALITY OF CARE

The issue of quality was a primary focus of the two PIPs undertaken by this health plan. The quality of healthcare, and the overarching issue of the quality of life of health plan members, were both addressed in these PIPs. Enacting measures to improve access to primary preventive care, and assisting members in obtaining mental health services in an outpatient setting, enhances the quality of services received by these members. In both projects the health plan stated their planned intention to incorporate these interventions into normal daily operations as the data indicated positive outcomes. Undertaking performance improvement projects that will develop into enhanced service provisions for members indicates a commitment to quality service delivery.

ACCESS TO CARE

The study topics presented in these PIPs addressed issues that will create improved services and enhance access to care for the health plan members. Although each PIP approached their respective problems differently, each created a potential for improved access to appropriate services, in the least restrictive environment.

TIMELINESS OF CARE

The major focus of these performance improvement projects was ensuring that members had timely access to care. By implementing strategies to ensure that members improve their use of outpatient treatment services within the seven-day timeframes of follow up after hospitalization for mental health treatment, the health plan positively impacts timely access to care. The project indicates that the health plan has a commitment to assisting members in engaging in timely treatment. The project focusing on increasing the use of appropriate asthma

medications also provides members with opportunities to obtain the most appropriate service in the most appropriate setting. By working with providers to encourage patients to make timely appointments it enables better health care outcomes.

RECOMMENDATIONS

1. Continue to utilize the protocols to develop and evaluate performance improvement studies. The quality of the studies submitted has improved significantly. Both studies provide evidence that there was a great deal of thought and consideration put into planning these studies, developing appropriate interventions, and creating a positive environment for the potential outcomes. This process will also ensure that as the studies are completed, effective data collection and analysis will occur.
2. Consider all interventions that may affect the projected outcomes. Ensure that there is adequate documentation to explain the impact of the interventions on the findings and outcomes.

11.2 Validation of Performance Measures

METHODS

Objectives, technical methods, and procedures are described under separate cover. This section describes the documents, data, and persons interviewed for the Validation of Performance Measures for Missouri Care. Missouri Care submitted the requested documents on January 28, 2008. The EQRO reviewed documentation between January 28, 2008 and July 1, 2008. On-site review time was used to conduct follow-up questions and provide feedback and recommendations regarding the performance measure rate calculation.

DOCUMENT REVIEW

The following are the documents reviewed by the EQRO:

- The Baseline Assessment Tool (BAT) submitted by Missouri Care
- MEDSTAT's NCOA HEDIS Compliance Audit Report for 2007
- Missouri Care's HEDIS Data Entry Training Manual
- Missouri Care's Policies pertaining to HEDIS rate calculation and reporting

The following are the data files submitted for review by the EQRO:

- ADV_File1_MoCare.txt
- ADV_File2_MoCare.txt
- AWC_FILE1_MoCare.txt
- AWC_File2_MoCare.txt
- AWC_File3_MoCare.txt
- FUH_ FILE1_MoCare.txt
- FUH_ FILE2.txt

INTERVIEWS

The EQRO conducted on-site interviews with Katie Dunne, Senior Quality Coordinator and Tammy Weise, Manager, Quality Management at Missouri Care Health Plan in Columbia, MO on Wednesday, July 16, 2008. This group was responsible for the process of calculating the HEDIS 2007 performance measures. The objective of the on-site visit was to verify the methods and processes behind the calculation of the three HEDIS performance measures. This included both manual and automatic processes of information collection, storing, analyzing and reporting.

FINDINGS

Missouri Care calculated the Follow-Up After Hospitalization for Mental Illness and Annual Dental Visit measures using the Hybrid Method. The administrative method was used to calculate the Adolescent Well-Care Visits measure.

MO HealthNet Managed Care health plan to MO HealthNet Managed Care health plan comparisons of the rates of Adolescent Well-Care Visits, Follow-Up After Hospitalization for Mental Illness, and Annual Dental Visit measures were conducted using two-tailed z-tests. For comparisons that were statistically significant at the 95% confidence interval (CI), the z-score (z), the upper and lower confidence intervals (CI), and the significance levels ($p < .05$) are reported.

The HEDIS 2007 rate for Missouri Care for the Adolescent Well-Care Visits measure was 44.91%, which was significantly higher than the statewide rate for all MO HealthNet Managed Care Health Plans (34.81%; $z = -0.33$, 95% CI: 28.89%, 40.74%; $p > .95$). This rate was also higher than the rate (41.19%) reported by the health plan during the 2004 External Quality Review.

The Follow-Up After Hospitalization for Mental Illness measure is reported as two

rates, one for 7-day follow-up and one for 30-day follow-up. The Follow-Up After Hospitalization rates reported to the SMA and the State Public Health Agency (SPHA) by Missouri Care were 42.58% (7-day rate) and 63.16% (30-day rate). The 7-day rate reported was consistent with the statewide rate for all MO HealthNet Managed Care Health Plans (35.52%; $z = -0.34$, 95% CI: 22.96%, 48.08%; n.s.); however, this rate was a vast improvement over the 7 day rate (17.65%) reported by the health plan during the 2006 review. The 30-day rate reported was significantly higher than the statewide rate for all MO HealthNet Managed Care Health Plans (60.06%; $z = 1.38$, 95% CI: 47.50%, 72.62%; $p > .95$) and was also higher than the 30 day rate (47.79%) reported by the health plan during the 2006 review.

The reported rate for Missouri Care for the Annual Dental Visit rate was 27.76%; significantly lower than the statewide rate for MO HealthNet Managed Care Health Plans (32.50%, $z = 0.04$; 95% CI: 29.30%, 35.69%; $p < .05$); this rate is also lower than the rate (28.66%) reported by the health plan during the 2005 review.

The following sections summarize the findings of the process for validating each of the performance measures in accordance with the Validating Performance Measures Protocol. The findings from all review activities are presented according to the EQRO validation activity, with the findings for each measure discussed within the activities as appropriate. Please refer to the tables in the main report for activities, ratings, and comments related to the CMS Protocol Attachments.

DATA INTEGRATION AND CONTROL

The information systems (IS) management policies and procedures for rate calculation were evaluated consistent with the Validating Performance Measures Protocol. For all three measures, Missouri Care was found to meet all

criteria for producing complete and accurate data (see Attachment V: Data Integration and Control Findings). There were no biases or errors found in the manner in which Missouri Care transferred data into the repository used for calculating the HEDIS 2007 measures.

DOCUMENTATION OF DATA AND PROCESSES

Missouri Care used Catalyst, an NCQA-certified software program in the calculation of the HEDIS 2007 performance measures. The EQRO was provided a demonstration of this software, as well as appropriate documentation of the processes and methods used by this software package in the calculation of rates. The EQRO was also provided with an overview of the data flow and integration mechanisms for external databases for these measures. Data and processes used for the calculation of measures were adequate (see Attachment VII: Data and Processes Used to Calculate and Report Performance Measures). Missouri Care met all criteria that applied for all three measures.

PROCESSES USED TO PRODUCE DENOMINATORS

Missouri Care met all criteria for the processes employed to produce the denominators of all three performance measures (see Attachment X: Denominator Validation Findings). This involved the selection of members eligible for the services being measured.

Missouri Care employed a 5% oversample for the Adolescent Well-Care Visits measure. No records were excluded for contraindications, making for a total sample of 432. This is within the specified range and allowable methods for proper sampling.

For the HEDIS 2007 Adolescent Well-Care Visits measure, there were a total of 5,376 eligible members listed by the health plan and validated by the EQRO. The DST showed a denominator of 432 eligible members after a 5% oversample.

There were no exclusions allowed for the measure, and no exclusions or replacements reported. There were no duplicate member names, identification numbers or dates of birth. The dates of birth were within the valid range and the dates of enrollment and codes for well care visits were provided.

For the HEDIS 2007 Follow-Up After Hospitalization measure, the DST showed a total of 209 eligible members for the denominator. The file of all administrative records supplied by the health plan contained 209 eligible members. There was no duplication of members and the dates of birth and dates of enrollment were within the valid range.

For the HEDIS 2007 Annual Dental Visit measure, there were a total of 14,945 eligible members reported and validated by the EQRO. There were no duplicate members and the dates of birth were in the valid range. The dates of enrollment were valid.

PROCESSES USED TO PRODUCE NUMERATORS

All three measures included the appropriate data ranges for the qualifying events (e.g., well-care visits, follow-up visits, and dental visits) as specified by the HEDIS 2007 criteria (see Attachment XIII: Numerator Validation Findings). A medical record reviews was conducted for the Adolescent Well-Care Visit measure.

For the Adolescent Well-Care Visit measure, Missouri Care reported 158 administrative hits from the sample of the eligible population; the EQRO validated all 158 of these hits. For the medical record review validation, the EQRO requested 30 records. A total of 30 records were received for review, and all 30 of those were validated by the EQRO. Therefore, the percentage of medical records validated by the EQRO was 100.00%. The rate calculated by the EQRO based on validated administrative and hybrid hits was 44.91%, which is the same rate reported by the health plan. Therefore, no bias was found.

For the HEDIS 2007 Follow-Up After Hospitalization measure, the health plan reported 89 administrative hits from the eligible population for the 7-day follow-up rate; the EQRO validated all 89 of these hits. The health plan reported 132 administrative hits from the eligible population for the 30-day follow-up rate; the EQRO validated 131 administrative hits. The reported 7-day rate was 42.58%, and the rate validated by the EQRO was the same, resulting in no bias found. The rate reported for the 30-day calculation was 63.16%, with the EQRO validating a rate of 62.68%. This represents an overestimate reported bias of 0.48%.

For the HEDIS 2007 Annual Dental Visit measure, the EQRO validated 4,137 of the 4,149 reported administrative hits. The health plan's reported rate was 27.76% and the EQRO validated rate was 27.68%, resulting in a bias (overestimate by the health plan) of 0.08%.

SAMPLING PROCEDURES FOR HYBRID METHODS

The Hybrid Method was used for the Adolescent Well-Care Visits measure. CMS Protocol Attachment XII; Impact of Medical Record Review Findings and Attachment XV: Sampling Validation Findings were completed for this measure.

SUBMISSION OF MEASURES TO THE STATE

Missouri Care submitted the DST for each of the three measures validated to the SPHA (the Missouri Department of Health and Senior Services; DHSS) in accordance with the Code of State Regulations (19 CSR §10-5.010 Monitoring Health Maintenance Organizations) and the SMA Quality Improvement Strategy.

DETERMINATION OF VALIDATION FINDINGS AND CALCULATION OF BIAS

The following table shows the estimated bias and the direction of bias found by the EQRO. There was no bias observed in calculation of the Adolescent Well-Care Visits and 7-day Follow-Up After Hospitalization measures. The 30-day Follow-Up After Hospitalization and Annual Dental Visit measures were slightly overestimated, but these results still fell within the 95% confidence interval reported by the health plan for these measures.

Table 80 - Estimate of Bias in Reporting of MOCare HEDIS 2007 Measures

Measure	Estimate of Bias	Direction of Estimate
Adolescent Well-Care Visits	No bias	n/a
Follow- Up After Hospitalization (7 days)	No bias	n/a
Follow-Up After Hospitalization (30 days)	0.48%	Overestimate
Annual Dental Visit	0.08%	Overestimate

FINAL AUDIT RATING



The Final Audit Rating for each of the performance measures was based on the findings from all data sources that were summarized in the Final Performance Measure Validation Worksheet for each measure. The table below summarizes Final Audit Ratings based on the Attachments and validation of numerators and denominators.



Table 81 - Final Audit Rating for MOCare Performance Measures

Measure	Final Audit Rating
Adolescent Well-Care Visits	Fully Compliant
Follow- Up After Hospitalization (7 days)	Fully Compliant
Follow-Up After Hospitalization (30 days)	Substantially Compliant
Annual Dental Visit	Substantially Compliant

Note: Fully Compliant = Measure was fully compliant with State specifications; Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate; A significant bias in the rate was defined as a number calculated by the EQRO that fell outside the 95% confidence interval of the rate reported by the health plan. Not Valid = Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported; Not Applicable = No MO HealthNet Managed Care Members qualified for the measure.

CONCLUSIONS

Four rates were validated for the health plan. One of these rates was significantly lower; one was consistent with; and two were significantly higher than the average for all MO HealthNet Managed Care Health Plans.

QUALITY OF CARE

Missouri Care's calculation of the HEDIS 2007 Follow-Up After Hospitalization for Mental Illness measure was either fully compliant (7-day calculation) or substantially complaint (30-day calculation) with specifications. This measure is categorized as an Effectiveness of Care measure and is designed to measure the effectiveness/quality of care delivered. The health plan's 7-day follow-up rate for this measure was significantly lower than the average for all MO HealthNet Managed Care Health Plans. The health plan's 30-day follow-up rate for this measure was significantly higher than the average for all MO HealthNet Managed Care Health Plans. Therefore, Missouri Care's members are receiving the quality of care for this measure that is lower than the average MO HealthNet Managed Care Health Plan member within the 7-day timeframe, but higher than the average member within the 30-day timeframe. However, both of these rates were higher than the National Medicaid rate, indicating that Missouri Care's

members are receiving a higher quality of care for this measure than the average Medicaid member across the nation. Both of these rates were also higher than the rates reported by the health plan during the 2006 review, thereby indicating that Missouri Care members were receiving a higher quality of care for the HEDIS 2007 measurement year than they were during the HEDIS 2006 measurement year.

The EQRO was able to validate the 7-day rate fully and therefore is extremely confident in the calculated rate. The 30-day rate was able to be validated within the reported 95% confidence intervals and thereby the EQRO has substantial confidence in the calculated rate.

ACCESS TO CARE

The HEDIS 2007 Annual Dental Measure for Missouri Care was substantially compliant with specifications; this measure is categorized as an Effectiveness of Care measure. Because only one visit is required for a positive “hit”, this measure effectively demonstrates the level of access to care that members are receiving. The rate reported by the health plan for this measure was significantly lower than the average for all MO HealthNet Managed Care Health Plans. Therefore, Missouri Care’s members are receiving a quality of care for this measure that is lower than the average MO HealthNet Managed Care member. Additionally, this rate was lower than the same rate reported by the health plan during the 2005 review, indicating that Missouri Care members are receiving lower quality of care for this measure than their counterparts were during the HEDIS 2005 measurement year.

This rate was able to be validated within the reported 95% confidence intervals and therefore the EQRO has substantial confidence in the calculated rate.

TIMELINESS OF CARE

The health plan’s calculation of the HEDIS 2007 Adolescent Well-Care Visits measure was fully compliant with specifications. This measure is categorized as a Use of Services measure and is designed to measure access to and timeliness of the care defined. The health plan’s reported rate for this measure was significantly higher than with the average for all MO HealthNet Managed Care Health Plans. This rate was also higher than the rate reported by the health plan

during the 2004 review. Therefore, Missouri Care's members are receiving a higher timeliness of care for this measure than the care delivered to the average MO HealthNet Managed Care member. Additionally, the reported rate was higher than both the National Medicaid Rate and the National Commercial Rate; Missouri Care is delivering a higher level of care than that received by the average Medicaid or Commercial member across the nation.

The EQRO was able to fully validate this rate and thereby has extreme confidence in the calculated rate.

RECOMMENDATIONS

1. The health plan's Follow-Up After Hospitalization Rate (7 day follow-up) was significantly lower than the average rate for all MO HealthNet Managed Care Health Plans. The EQRO recommends the health plan concentrate efforts to improve this rate.
2. Continue to conduct and document statistical comparisons on rates from year to year.
3. Continue to participate in training of health plan staff involved in the oversight of coordination of performance measure calculation.
4. Continue to perform hybrid measurement on those measures that are available for this method of calculation. The Adolescent Well-Care measure rate was significantly higher than those health plans that did not use the hybrid methodology.

11.3 Validation of Encounter Data

FINDINGS

The findings for the encounter data validation are organized according to the encounter data evaluation questions presented in the Technical Methods section for the encounter data validation in the aggregate report. Please refer to the main report for detailed objectives, technical methods and procedures for encounter data validation.

What is the Baseline Level of Completeness, Accuracy, and Reasonableness of the Critical Fields?

For the Medical claim type, there were 80,857 encounter claims paid by the SMA for the period July 1, 2007 through September 30, 2007.

1. The Outpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Outpatient Recipient ID field was 100.00% complete, accurate and valid.
3. The Outpatient First Date of Service field was 100.00% complete, accurate and valid.
4. The Outpatient Last Date of Service field was 100.00% complete, accurate and valid.
5. The Outpatient Units of Service field was 100.00% complete, accurate and valid.
6. The Outpatient Procedure Code field was 100.0% complete, accurate and valid.
7. The Outpatient Place of Service field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 100.00% complete, accurate and valid.
9. Although the second through fifth Diagnosis Code fields are optional according to the Health Plan Record Layout Manual, the second, third, fourth and fifth Diagnosis Code fields were well below the SMA threshold of 100.00%

for completeness, accuracy and validity. The Diagnosis Code fields were 49.16%, 23.35%, 11.38%, and 0.00% complete, accurate and valid, respectively. The remaining fields were blank (incomplete, inaccurate and invalid).

For the Dental claim type, there were 9,856 encounter claims paid by the SMA for the period July 1, 2007 through September 30, 2007. All fields examined excluding the first and fifth Diagnosis fields were 100.00% complete, accurate and valid.

For the Home Health claim type, there were no encounter claims paid by the SMA for the period July 1, 2007 through September 30, 2007.

For the Inpatient claim type, there were 10,491 encounter claims paid by the SMA for the period July 1, 2007 through September 30, 2007.

1. The Inpatient Claim Type field was 100.00% complete, accurate and valid.
2. The Recipient ID field was 100.00% complete, accurate and valid.
3. The Admission Type field was 100.00% complete, accurate and valid.
4. The Admission Date field was 100.00% complete and accurate, and valid.
5. The Discharge Date field was 100.00% complete, accurate and valid.
6. The Bill Type field was 100.00% complete, accurate and valid.
7. The Patient Status field was 100.00% complete, accurate and valid.
8. The first Diagnosis Code field was 100.0% complete, accurate and valid.
9. The second, third, fourth and fifth Diagnosis Code fields fell well below the 100% threshold for completeness, accuracy, and validity established by the SMA (92.0%, 76.73%, 58.58%, and 45.80% respectively). The remaining fields were blank (incomplete, inaccurate, and invalid).
10. The First Date of Service field was 100.00% complete, accurate and valid.
11. The Last Date of Service field was 100.00% complete, accurate and valid.
12. The Revenue Code field was 99.99% complete, accurate, and valid. Two fields were blank (incomplete, inaccurate, and invalid).
13. The Units of Service field was 100.00% complete, accurate and valid.

For the Outpatient Hospital claim type, there were 60,184 encounter claims paid by the SMA for the period July 1, 2007 through September 30, 2007. Missouri Care had 100.00% complete, accurate and valid data for all fields examined, except the Procedure Code, second, third, fourth and fifth Diagnosis Codes.

1. The Procedure Code field was 97.34% complete and accurate, The remaining fields (n=2026) were blank. The Procedure Code field was 78.59% valid. The remaining fields were blank (n=2026) or contained invalid codes

(n=10,858).

2. The second Diagnosis Code field was 52.90% complete, accurate, and valid. The remaining fields were blank (n = 28,834).
3. The third Diagnosis Code field was 25.53% complete, accurate and valid. The remaining fields were blank (incomplete, inaccurate, and invalid).
4. The fourth Diagnosis Code field was 12.08% complete, accurate, and valid. The remaining Diagnosis Code fields were blank (n = 52,916).
5. The fifth Diagnosis Code field was 6.17% complete, accurate and valid. All remaining Diagnosis Code fields were blank (incomplete, inaccurate, and invalid).

For the Pharmacy claim type, there were 53,084 claims paid by the SMA for the period July 1, 2007 through September 30, 2007. Missouri Care had 100.00% complete, accurate and valid data for all fields examined.

What Types of Encounter Claim Data are Missing and Why?

Based on the above analysis of the accuracy, completeness, and validity of the data in the SMA encounter claims extract file for Missouri Care, an error analysis of the invalid entries was conducted for fields which were lower than the 100.00% threshold specified by the SMA. All critical fields for the Inpatient, Outpatient Medical, Dental and Pharmacy claim types were 100.00% complete, accurate, and valid (see previous findings). The Outpatient Hospital Claim type had invalid data in the Procedure Code fields.

What is the Level of Volume and Consistency of Services?

When comparing the rate of encounter claim types per 1,000 members, the rates for Outpatient Hospital claim types were significantly higher than the average for MO Health Net Managed Care Health Plans. The rates for all other claim types were consistent with the average for MO HealthNet Managed Care

Health Plans. This suggests high rates of encounter data submission and access to preventive and acute care.



To What Extent do the Claims in the State Encounter Claims Database Reflect the Information Documented in the Medical Record? What is the Fault/Match Rate between State Encounter Claims and Medical Records?

To examine the degree of match between the SMA encounter claims database and the medical record, 100 encounters from each MO HealthNet Managed Care Health Plan were randomly selected from all claim types for the period July 1, 2007 through September 30, 2007 for medical record review.

Of the 214,472 encounter claim types in the SMA extract file for July 1, 2007 through September 30, 2007, 100 encounters were randomly selected. Providers were requested to submit medical records for review. There were 98 medical records (98.0%) submitted for review. Encounters for which no documentation was submitted were unable to be validated. The match rate for procedures was 58.0%, with a fault rate of 42.0%. The match rate for diagnoses was 60.0%, with a fault rate of 40.0%.

What Types of Errors Were Noted?

An error analysis of the errors found in the medical record review for procedure, diagnosis, name of drug dispensed, and quantity of drug dispensed was conducted.

For the procedure codes in the medical record, the reasons for procedure codes in the SMA extract file not being supported by documentation in the medical record were missing information (n = 42). For the diagnosis codes in the medical record, the reasons for diagnosis codes in the SMA extract file not being supported by documentation in the medical record was missing information (n = 40). Examples of missing information include no code; codes listed that were not supported, or codes that did not match the procedure description.

To what extent do the MO HealthNet MCHP paid/unpaid encounter claims match the SMA paid database?

Since Missouri Care included internal control numbers that matched those of the SMA, the EQRO conducted the planned analyses comparing MO HealthNet Managed Care Health Plan encounter data to the SMA encounter claim extract file. The SMA defined “unpaid claims” as those claims that the health plan denied for payment, unpaid claims do not include claims paid via a capitation plan.

For the Pharmacy Claim type, all encounter data submitted to the EQRO was of “paid” status. There were zero unmatched claims that were in the MOCare encounter file and absent from the SMA data. Thus, 100.0% of the EQRO submitted encounters matched with the SMA encounter records.

For all Outpatient Claim Types (Medical, Dental, and Hospital), MOCare submitted 150,897 “paid” encounters, 163 “denied” claims and one “unpaid” claim. All paid encounter claims matched with the SMA encounter claim extract file. The 163 denied claims and 1 unpaid claim were not present in the SMA database (as expected); there was a “hit” rate of 99.89% between MOCare encounter claims and the SMA encounter data.

For the Inpatient Claim Type, MOCare submitted 10,491 encounter claims of “paid” status and 17 “denied” claims. All paid encounter claims matched with the SMA encounter claim extract file. The denied claims were not present in the SMA database.

Why are there unmatched claims between the MO HealthNet Managed Care Health Plan and SMA data files?

The unmatched encounters are due to missing ICN numbers which are required to match the encounter to that of the SMA. Therefore, in all claim types, the

encounter claims were legitimately missing from the SMA extract data.



What are the Data Quality Issues Associated with the Processing of Encounter Data?

While the MO HealthNet Managed Care Health Plan did submit the data in the requested format (including most ICN numbers), there are a number of ways to improve the data quality by improving the database system. As the Internal Control Number is only assigned by the State database when a claim is paid, it is difficult to match the health plan data of “unpaid” and “denied” claims to the SMA data. As the Internal Control Number is unique only to the encounter, the ICN may be represented in multiple lines of data. To match the MO HealthNet Managed Care Health Plan data to the SMA data to specific fields, this requires a unique line number. Therefore each service provided within an encounter would have a separate line of data with a unique line identifier.

CONCLUSIONS

STRENGTHS

1. Encounter data was submitted to the EQRO in the requested format and even included internal control numbers which enabled BHC to conduct the planned comparisons between the MO HealthNet Managed Care Health Plan and the SMA extract files.
2. The critical field validation of all six claim types resulted in few fields under the SMA established threshold of 100.00% accuracy, completeness, and validity.
3. The critical fields examined for the Dental, Outpatient Medical, and Pharmacy claim types were 100.00% complete, accurate and valid.
4. The rates for Outpatient Hospital claims were significantly higher than the average for MO HealthNet Managed Care Health Plans, suggesting high rates of encounter data submission and at least moderate access to preventive and acute care.

AREAS FOR IMPROVEMENT

1. The Inpatient Revenue Code fields contained invalid (blank) entries.
2. The Outpatient Procedure Code fields contained invalid entries.
3. The health plan reported no Home Health encounter claims during the review period.

RECOMMENDATIONS

1. Examine and revise as needed internal system edits for invalid procedure codes in the NSF/CMS 1500 file layout for the Outpatient Procedure Code and run validity checks after the programming of new edits.
2. Ensure that Revenue Code fields are complete and valid for the Inpatient (UB-92) claim types, and institute error checks to identify invalid data.
3. Include all State issued ICN numbers for all encounters to allow more accurate matching of encounters between the MO HealthNet Managed Care Health Plan and SMA extract files.

11.4 MO HealthNet MCHP Compliance with Managed Care Regulations

METHODS

Prior to the site visit, documentation was received and reviewed regarding the MO HealthNet Managed Care Health Plan's compliance with the State contract. The External Quality Review Organization (EQRO) reviewed contract documents with the staff of the MO HealthNet Division (MHD). On-site review time was used to conduct interviews with those who oversee and conduct the daily activities of the health plan to ensure that documentation is developed and practices occur within the scope of the contract and in a manner that meets or exceeds federal regulations.

A detailed protocol (BHC MO HealthNet Managed Care Health Plan Compliance Review Scoring Form) was utilized to ensure that all the elements of the federal regulations were addressed in the review process. Additionally, an interview tool was constructed to validate practices that occur at the health plan and to follow-up on questions raised from the document review and from the 2006 External Quality Review. Document reviews occurred on-site to validate that practices and procedures were in place to guide organizational performance.

DOCUMENT REVIEW

The Division of Medical Services supplied:

- State of Missouri Contract Compliance Tool (including DMS responses and comments)

The following documents were requested for on-site review:

- Member Handbook
- Provider Handbook
- Policy Tracking Log
- Staff Training Log
- Credentialing Policies and Audit Reports
- Grievance Logs (Member and Providers)
- 2007 Annual Quality Improvement Program Evaluation

Additional documentation made available by Missouri Care Health Plan included:

- Marketing Plan and Educational Material Development Policy
- 2007 Marketing Materials
- Missouri Care Organizational Chart
- Missouri Care Provider Directory
- Missouri Care Informational Handouts

INTERVIEWS

Interviews were conducted with the following groups:

Plan Administration

- Pamela Johnson, Executive Director
- Dr. Andrew Matera, Chief Medical Officer
- Melody Dowling, UM Manager
- Tammy Weise, Manager, Quality Management
- Brenda Moore, Manager, Medical Management
- Debby Langley, Manager, Member Solutions
- Brent Netemeyer, Director, Operations
- Katie Dunne, Senior Quality Coordinator



Member Services Staff

- Michelle Sandbothe, Member Services
- Chiquita Chatmon, Member Services
- Debby Langley, Manager, Member Solutions

Case Management Staff

- Dr. Andrew Matera, Chief Medical Officer
- Melody Dowling, UM Manager
- Mary Strata, Case Manager
- Brenda Moore, Manager, Medical Management
- Jeanette Hogan, Case Manager
- Amanda Lucas, Case Manager

FINDINGS

ENROLLEE RIGHTS AND PROTECTIONS

Missouri Care has an assigned compliance officer who maintained a record of all internal policies and presented reminders to appropriate staff when annual reviews were required. Compliance reviews are conducted every other month. Records included all initial approval dates to ensure that timely monthly reminders were produced. Revisions were made as necessary. Internal approval included the Quality Management Oversight Committee, Managers, the Chief Medical Director, and the Executive Director prior to submission to the SMA.

The health plan continues to utilize the Child and Adolescent Health Measurement Initiative (CAHMI) survey instrument for member needs assessment. Missouri Care utilized the monthly special needs listing produced by the SMA and sent the survey to all of their members appearing on this listing. If they received no response in seven days, and again in fourteen days, they

made additional attempts using telephone contacts. If the health plan was unable to contact the member after 30 days, the file was closed. Missouri Care reported they send out 75-100 CAHMI's each month and have a 30-35% response rate. The health plan finds that using the CAHMI assists in correctly identifying members who need physical or mental health case management services.

The health plan discussed identified dissatisfaction expressed by members with provider communication. This was originally identified in the 2005 CAHPS Survey and the health plan continues to monitor this issue. Missouri Care used both their newsletters to members and providers to discuss the issue of positive communication techniques. The health plan has identified a reduction in the complaints from members.

Missouri Care continues to participate in community-based programs throughout the Central Region. They were involved in school-based health clinics whenever possible. They participated in a back-to-school fairs where they not only contacted member families directly, but were able to network with regional primary care physicians (PCPs). Additionally, outreach calls were made to all eligible children. One local Federally Qualified Health Center (FQHC) conducts evening appointments to do Pap tests and adolescent EPSDT examinations. As a trial intervention, Missouri Care scheduled appointments for the FQHC utilizing demographic information obtained from their system. These efforts resulted in additional examinations. Through efforts with the Columbia Public Schools, the health plan continues its targeted campaign to increase EPSDT examinations in the Boone County section of the region. EPSDT examinations for high school students were planned at the new Family Health Clinic satellite location near the Frederick Douglas High School building. A quarterly newsletter for school nurses was developed and continues to be distributed by the health plan.

Member Services staff report receiving training on both the federal regulations and MO HealthNet Managed Care contract requirements. They are also trained on AETNA policy, and local health plan specific policies and procedures. These staff members are aware of their responsibility to contact new members and provide a full explanation of health care benefits that are available. The Member Services staff explained that non-English speaking members were provided access to the Language Line and assisted to select providers with

appropriate language capabilities. They also utilize staff members at the University of Missouri to assist with any extraordinary language issues. The Member Services staff viewed themselves as advocates for the health plan members. They give overviews of the handbook, explain benefits, problem solve with members, and assist members in finding providers and obtaining timely appointments.

Case Managers accept referrals from various sources including physicians, the enrollment broker, outreach events, the health plan's medical director, Lutheran Family Services, WIC, SMA special needs information, Provider Representatives, Behavioral Health case managers and providers, Prior Authorization staff, Concurrent Review Nurses, the Regional Center, and Family Support Division case workers. If the referral is for OB case management, the member is contacted within seven to ten days.

Case Managers discussed the process when they receive a referral. A general assessment is completed, followed by an assessment pertinent to any detectable disease process. A plan of care is developed with the member. Needs, such as transportation or referrals to community resources, are identified and services are put in place. Children may be referred to First Steps, or a member may receive an additional referral to behavioral health services. All members identified as having special health care needs are also given the CAMHI Survey, which adds depth to the assessment process. The member and their provider are given copies of the member's profile. Pharmacy profiles are also sent to the PCP. All information is entered into the health plan's system, which also allows for co-case management. Case managers make frequent calls to members to ensure that they participate in the care and treatment required. Members are informed of their right to refuse treatment and also to execute an advance directive.

The rating for Enrollee Rights and Protections (100%) reflects that the health plan substantially complied with the submission and approval of all policy and procedures to the SMA for the second year. All practice observed at the on-site review indicates that the health plan appears to be fully compliant with MO HealthNet Managed Care Contract requirements and federal regulations in this area.

Table 82 – Subpart C: Enrollee Rights and Protections Yearly Comparison (MOCare)

Federal Regulation	Missouri Care		
	2005	2006	2007
438.100(a) Enrollee Rights: General Rule	2	2	2
438.10(b) Enrollee Rights: Information Requirements	2	2	2
438.10(c)(3) Alternative Language: Prevalent Language	2	2	2
438.10(c)(4,5) Language and Format: Interpreter Services	2	2	2
438.10(d)(1)(i) Information Requirements: Format/Easily Understood	2	2	2
438.10(d)(1)(ii) and (2) Information Requirements: Format Visually Impaired, and Limited Reading Proficiency	2	2	2
438.10(f) Information for All Enrollees: Free Choice, etc.	2	2	2
438.10 (g) Information to Enrollees: Specifics/Physician Incentive Plans	2	2	2
438.10(i) Special Rules: Liability for Payment/Cost Sharing	2	2	2
438.100(b)(2)(iii) Enrollee Rights: Provider-Enrollee Communications	2	2	2
438.100(b)(2)(iv,v) Rights to Refuse Services/Advance Directives	2	2	2
438.100(b)(3) Right to Services	1	2	2
438.100(d) Compliance with Other Federal/State Laws	2	2	2
Number Met	12	13	13
Number Partially Met	1	0	0
Number Not Met	0	0	0
Rate Met	92.3%	100.0%	100.0%

Note: 0 = Not Met; 1= Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols.

BEHAVIORAL HEALTH

In 2005, through efforts with the SMA, the University of Missouri, and other State agencies, Missouri Care made tele-psychiatry services available in six counties in the Central Missouri region. This service continues to be available and creates access in outpatient offices for use by specialist psychiatrists. Face-to-face sessions with the member's behavioral health provider are required. Pediatric and adolescent psychiatrists are available through this method to outlying counties, where these services would normally be unavailable. In some cases,

the parent and case manager participated in sessions with the member and psychiatrist. This innovation creates a more comprehensive approach to treatment for a number of members.

Missouri Care reports that provider availability has improved during 2006 and 2007. There is a larger network using smaller in-home provider groups, as well as independent providers. The health plan believes that working directly within the Central Region communities, they have been able to identify and recruit mental health providers that are regionally based. These providers are often keenly aware of community and family issues that assist members in obtaining the best service in the most convenient environment. The health plan found that issues such as drug overdoses are now treated appropriately. In the past, members were seen in an emergency room and released. Efforts to educate providers have created an atmosphere where the health plan is notified and follow-up services are put in place in an expedient manner.

Members who require inpatient treatment are served directly by case management staff. Case managers assist the member in obtaining an inpatient bed, and work to ensure that appropriate aftercare services are arranged. The health plan finds that overall inpatient days have been reduced and outpatient service utilization has increased.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

Access Standards

New and additional specialties have been added to the Missouri Care network through an agreement with Kansas City Children's Mercy Hospital during 2006. The MO HealthNet Managed Care Health Plan also worked with St. Louis Children's Hospital to obtain an agreement. These additions have made orthopedic services more accessible to members. Pediatric cardiology and neurology are available at the University of Missouri Hospital and Clinics. Dental

care continues to be a problem, and the health plan reported that they are moving their subcontract for dental services to Delta Dental to improve the availability of services. The health plan continues its recruitment efforts in this area.

The health plan began using a predictive model to identify candidates for case management. This model, Pathways, gives a profile which helps to identify the potential for case management. Through the information obtained from this system, the case manager can determine the reasons for accessing care in the emergency room. Other categories of care explored include the providers that have been utilized, how much pharmacy usage has occurred, and what durable medical equipment was authorized and purchased. On the daily patient census, a drill down can provide reasons for admission such as maternity, behavioral health verses physical health, as well as identifying the inpatient facility used and the length of stay. This program refreshes every three hours and is linked to Milliman Guidelines for utilization review purposes. A link also exists to review notes. This model gives a quick look at member activity for a one year timeframe. The health plan believes the model will be useful to both case management staff and providers. It will allow the Medical Director to discuss a case with the Primary Care Physician and will enable them to ask and resolve questions quickly.

Prenatal case management continues to be a focus of the care provided to health plan members. The health plan staff continues to use the global OB form, which includes risk factors and points to the need for case management. Referrals are sometimes made to the Department of Social Services Children's Division for in-home services from this information. The information also generates a notice when members are identified as pregnant. The system generates a packet of information, educational material for members, and notices for visits that can be used as incentives to maintain scheduled appointments.

The Missouri Care Nurse Line call center, located in Phoenix, Arizona, is staffed 24 hours per day, seven days per week. Both nurse and physician coverage is available. After-hours access to local providers has improved. During 2006 four clinics were found to be out of compliance. Education and follow-up activities occurred. Recent checks indicate that these clinics are now complying with after-hours requirements and are compliant. This follow-up information was obtained through a follow-up survey completed in April 2007.

Member Services staff explains that many of their calls concern provider access. They coordinate information with the Nurse Advice Line. The use of this line does generate the use of available urgent care centers, rather than inappropriate use of emergency rooms. Another frequent call received is complaints about not being able to access providers after hours. This information is forwarded to the Provider Relations department. The Member Service staff works with the health plan member to identify alternative providers or to identify other resources, such as the Nurse Advice Line, that can assist the member during non-business hours. Member Services staff also contact providers directly to assist members in obtaining timely appointments, with prescription information, and to ensure that the provider has all information necessary to serve the member. If a member reports information that appears to be a complaint, the information is recorded in the health plan's system, and is referred to the Grievance and Appeal unit.

Case Managers work directly with members through the assessment process and directly refer them to appropriate providers so they obtain the health care services they require. They work directly with the member to develop a "care" (treatment) plan. They include providers in this process to enhance the plan and to ensure that all available services are part of the plan. The Case Managers work with other health plan staff, such as Concurrent Review Nurses, to ensure that they are aware of all members needing case management, and to expand

their knowledge of the services needed by health plan members. The Case Managers co-case manage with the Behavioral Health unit. These units discuss cases, refer to one another, and work collaboratively in providing services to members. One unit becomes the primary source of contact with members to avoid confusion.

Case Managers and Member Services staff expressed a commitment to ensuring that members have the health care services they need. They contact providers, include them in treatment planning, and advocate for member when necessary. The member centered atmosphere was evident in the responses received to questions.

The rating for Access Standards (100%) indicates the health plan's commitment to maintaining full compliance with all MO HealthNet Managed Care requirements and federal regulations. All practice in this area observed at the time of the on-site review indicated that Missouri Care worked toward ensuring that members have access to all the healthcare services that they may require.

Table 83 – Subpart D: Quality Assessment and Performance Improvement: Access Standards Yearly Comparison (MOCare)

Federal Regulation	Missouri Care		
	2005	2006	2007
438.206(b)(1)(i-v) Availability of Services: Provider Network	2	2	2
438.206 (b) (2) Access to Well Woman Care: Direct Access	2	2	2
438.206(b)(3) Second Opinions	2	2	2
438.206(b)(4) Out of Network Services: Adequate and Timely Coverage	2	2	2
438.206(b)(5) Out of Network Services: Cost Sharing	2	2	2
438.206(c)(1)(i-vi) Timely Access	2	2	2
438.206(c)(2) Provider Services: Cultural Competency	2	2	2
438.208(b) Care Coordination: Primary Care	2	2	2
438.208(c)(1) Care Coordination: Identification	2	2	2
438.208(c)(2) Care Coordination: Assessment	2	2	2
438.208(c)(3) Care Coordination: Treatment Plans	2	2	2
438.208(c)(4) Care Coordination: Direct Access to Specialists	2	2	2
438.210(b) Authorization of Services	2	2	2
438.210(c) Notice of Adverse Action	2	2	2
438.210(d) Timeframes for Decisions, Expedited Authorizations	1	2	2
438.210(e) Compensation of Utilization Management Activities	2	2	2
438.114 Emergency and Post-Stabilization Services	1	2	2
Number Met	15	17	17
Number Partially Met	2	0	0
Number Not Met	0	0	0
Rate Met	88.2%	100.0%	100.0%

Note: 0 = Not Met; 1= Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols.

Structures and Operation Standards

Credentialing policies and practices were reviewed on-site. All credentialing performed by Missouri Care meets NCQA standard and complies with federal and state regulations, and the SMA contract requirements. Re-credentialing is completed at three-year intervals, and delegated entities are monitored annually. State and federal sanctions are monitored monthly using the HHS

OIG/OPM (Office of Inspector General/Office of Personnel Management) web site. Internal information regarding grievances and quality issues are also monitored. Compliance with policies related to advance directives is monitored in records of primary care providers prior to re-credentialing (for PCP, hospital, home health agency, personal care provider or hospice). Confidentiality, nondiscrimination and rights to review files and to appeal are all included.

Delegation agreements are developed in accordance with Missouri Care policy. The delegation of responsibility must include all delegated activities and the organization's accountability for those activities. Five entities were audited in 2006. Four passed. One, Crown Optical, was re-audited on three subsequent occasions, with an emphasis on policies and procedures. Full compliance was achieved in January 2007.

Member Services staff was questioned about their response to members who requested disenrollment. They explore the request with the member to ensure that it is not a resolvable issue. If the problem is related to a provider, such as wishing to access a PCP outside of the network, Provider Relations is involved to attempt to recruit the provider into the Missouri Care network. If the problem can not be solved, the Member Services staff member refers the member to the Enrollment Department so the process can be completed. If the problem is the result of an issue that should be a grievance or appeal, this type of referral is made and sent to that unit. Member Services staff relates that they have experienced an issue that appeared to be a fraud and abuse situation, this information was referred to Provider Relations for further action.

The rating for Structure and Operations (100%) reflects full compliance with the MO HealthNet Managed Care contract requirements and federal regulations for the third consecutive year. The health plan submitted all required policy for approval, and all practice observed at the time of the on-site review indicated

compliance in this area. All credentialing policy and practice was in place. All disenrollment policy was complete and all subcontractual requirements were met.



Table 84 – Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards Yearly Comparison (MOCare)

Federal Regulation	Missouri Care		
	2005	2006	2006
438.214(a,b) Provider Selection: Credentialing/Recredentialing	2	2	2
438.214(c) and 438.12 Provider Selection: Nondiscrimination	2	2	2
438.214(d) Provider Selection: Excluded Providers	2	2	2
438.214(e) Provider Selection: State Requirements	2	2	2
438.226 and 438.56(b)(1-3) Disenrollment: Requirements and limitations	2	2	2
438.56(c) Disenrollment Requested by the Enrollee	2	2	2
438.56(d) Disenrollment: Procedures	2	2	2
438.56(e) Disenrollment: Timeframes	2	2	2
438.228 Grievance System	2	2	2
438.230(a,b) Subcontractual Relationships and Delegation	2	2	2
Number Met	10	10	10
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	100.0%

Note: 0 = Not Met; 1 = Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols.

Measurement and Improvement

Missouri Care operated a Quality Management Oversight Committee made up of the Chief Executive Officer, Plan Administrator, Chief Medical Officer, and department managers. The goal of this group was to provide oversight of all operations and health plan initiatives. The health plan adopted and disseminated practice guidelines in the areas of diabetes, asthma, chronic obstructive pulmonary disease (COPD), ADHD, and congestive heart failure. This information was available to all providers on the health plan's website. Missouri Care indicated that they were in the process of developing practice guidelines for depression management. Disease management is directed from the health plan Corporate Office and covers asthma treatment, COPD, diabetes

and CHF. Co-case Management can occur when it is in the member's best interest.



Sentinel events and quality of care issues are tracked to identify patterns that may evolve. Any suspected issue is taken to committee for discussion. If a problem is identified or suspected, follow-up occurs immediately. Outside review is then requested. Potential issues with providers in a facility have been addressed by facility staff.

The health plan submitted two Performance Improvement Projects (PIPs), which included enough information to complete validation. All Performance Measurement data and medical records requested were submitted for validation within requested timeframes. Missouri Care did have a health information system (HIS) capable of meeting the MO HealthNet Managed Care program requirements. The health plan also submitted all required encounter data in the format requested. The specific details can be found in the appropriate sections of this report.

Member Services has had no requests for practice guidelines, or other issues related to Measurement and Improvement. Case Managers report that they are aware of practice guidelines. They have not had members call and specifically ask for these. Members do call and ask about medication management and other issues that are pertinent to existing practice guidelines. They may ask a member if they want a copy to take with them to an appointment to ensure that all medical care is received.

The rating for the Measurement and Improvement section (100%) reflects that all required policy and procedure had been submitted to the SMA for their approval for the third consecutive year. It appeared that all practice observed at the time of the on-site review met the requirements of the MO HealthNet Managed Care contract and the federal regulations.

Table 85 – Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement Yearly Comparison (MOCare)

Federal Regulation	Missouri Care		
	2005	2006	2007
438.236(b)(1-4) Practice Guidelines: Adoption	2	2	2
438.236(c) Practice Guidelines: Dissemination	2	2	2
438.236(d) Practice Guidelines: Application	2	2	2
438.240(a)(1) QAPI: General Rules	2	2	2
438.240(b)(1) and 438.240(d) QAPI: Basic Elements of MCO Quality Improvement and PIPs	2	2	2
438.240(b)(2)(c) and 438.204(c) QAPI: Performance Measurement	2	2	2
438.240(b)(3) QAPI: Basic Elements/Over and Under Utilization	2	2	2
438.240(b)(4) QAPI: Basic Elements regarding Special Healthcare Needs	2	2	2
438.240(e) QAPI: Program Review by State	NA	NA	NA
438.242(a) Health Information Systems	2	2	2
438.242(b)(1,2) Health Information Systems: Basic Elements	2	2	2
438.242(b)(3) Health Information Systems: Basic Elements	2	2	2
Number Met	11	11	11
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	100.0%

Note: Regulation 438.240(e) refers to program review by the state. The regulation requires the state to review, at least annually, the impact and effectiveness of each MCHP's quality assessment and performance improvement program. The regulation refers to the state QA & I program review process and is not applicable to External Quality Review of the MC+ Managed Care Program. This percent is calculated for the regulations that are applicable to the MC+ Managed Care Program. 0 = Not Met; 1 = Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols.

Grievance Systems

The grievance system operates efficiently in this office. The health plan staff explained that when they receive provider complaints, these are reviewed by the provider representatives in the provider offices. They find that most of these complaints are the result of claims issues, such as timely filing. Many of these resulted from behavioral health providers who do not submit invoices within prescribed timeframes. The health plan believes this issue will be resolved with

training and continued support from the provider representatives. The Medical Director is maintaining regular communications with the providers, resulting in fewer calls or formal complaints being filed.

Member Services staff reports that when a call is received from a member who wished to file a grievance, information regarding who was involved and what happened is entered into the call tracking system and sent to the Member Services Manager for referral to the Grievance Unit. If the information involves a provider, Provider Relations is involved. The staff indicates an awareness of the grievance resolution process and the need for expedited resolution. Member Services staff indicated that they assist members in writing a grievance if necessary. It was reported that grievances and appeals are trended and sent to the Quality Management Committee for review and action. Trends are observed and follow-up with the appropriate providers, or health plan unit, occurs to resolve issues that may be leading to the grievances or appeals.

Case Managers reported that they are aware of the process for assisting members in filing a grievance. They stated that if a member contacts them with a complaint, they inform the member of their right to file a grievance and encourage them to follow through with this process. If the member wishes to file the grievance, the case manager assists them through the process. The actual filing is handled by the Member Services Department. If the member is dissatisfied with the outcome they are informed of their right to file a State Fair Hearing. Case Managers are also contacted when members receive a negative authorization decision. The Case Manager assists the member in following up with the PCP or physician to ensure that adequate information was provided, or in filing the appeal.

The rating for Grievance Systems (100%) reflects that all policy and practice met the requirements of the MO HealthNet Managed Care contract and federal requirements for the third consecutive year. It was evident, both in reviewing policy, grievance documentation, and in discussing this process with health plan staff that the grievance and appeal process was taken seriously. Staff expressed the opinion that this was an essential protection for members.



Table 86 – Subpart F: Grievance Systems Yearly Comparison (MOCare)

Federal Regulation	Missouri Care		
	2005	2006	2007
438.402(a) Grievance and Appeals: General Requirements	2	2	2
438.402(b)(1) Grievance System: Filing Requirements - Authority	2	2	2
438.402(b)(2) Grievance System: Filing Requirements - Timing	2	2	2
438.402(b)(3) Grievance System: Filing Requirements - Procedures	2	2	2
438.404(a) Grievance System: Notice of Action - Language and Format	2	2	2
438.404(b) Notice of Action: Content	2	2	2
438.404(c) Notice of Action: Timing	2	2	2
438.406(a) Handling of Grievances and Appeals: General Requirements	2	2	2
438.406(b) Handling of Grievance and Appeals: Special Requirements for Appeals	2	2	2
438.408(a) Resolution and Notification: Basic Rule	2	2	2
438.408(b,c) Resolution and Notification: Grievances and Appeals - Timeframes and Extensions	2	2	2
438.408(d)(e) Resolution and Notification: Grievance and Appeals - Format and Content of Notice	2	2	2
438.408(f) Resolution and Notification: Grievances and Appeals - Requirements for State Fair Hearings	2	2	2
438.410 Expedited Resolution of Appeals	2	2	2
438.414 Information about the Grievance System to Providers and Subcontractors	2	2	2
438.416 Recordkeeping and Reporting Requirements	2	2	2
438.420 Continuation of Benefits while Appeal/Fair Hearing Pends	2	2	2
438.424 Effectuation of Reversed Appeal Resolutions	2	2	2
Number Met	18	18	18
Number Partially Met	0	0	0
Number Not Met	0	0	0
Rate Met	100.0%	100.0%	100.0%

Note: 0 = Not Met; 1= Partially Met; 2 = Met

Sources: Department of Health and Human Services Centers for Medicare & Medicaid Services (2003). Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al. Final Protocol Version 1.0.; BHC, Inc., 2004 External Quality Review Monitoring MCOs Protocols

CONCLUSIONS

Missouri Care continues with their commitment to meeting all policy, procedure, and practice requirements to be in compliance with the MO HealthNet Managed Care contract and the federal regulations. The health plan utilized the tools produced by the 2005 and 2006 External Quality Review as guidelines in ensuring that required written materials were submitted to the SMA in a timely and efficient manner. The staff within Missouri Care exhibited a commitment to quality and integrity in the work with their members. The health plan utilized unique processes, such as bringing the provision of behavioral health services into the organization, as a method for improving the access, quality and timeliness of member services. Missouri Care created tools to educate and inform the community and providers, evidenced by the efforts made to improve EPSDT examination numbers. The health plan demonstrates an attitude of respect toward their members in a number of outreach initiatives, as well as efforts to utilize software tools to better identify special healthcare needs. Missouri Care attempted to create a healthcare service system that was responsive and assists members in overcoming the barriers they encounter in a largely rural area.

Staff reflected a new sense of energy and animation in the response to questions that appeared to be a reflection of health plan leadership. They discussed improved communication and collaboration within their organization.

QUALITY OF CARE

Quality of care is a priority for Missouri Care. Their attention to internal and external problem solving, supporting and monitoring providers, and participation in community initiatives are evidence of a commitment to quality healthcare. Missouri Care completed all policy requirements and has put processes in place to ensure that procedures and practices follow approved policy requirements.

A commitment to obtaining quality service for members is evident in interviews with health plan staff, who express enthusiasm for their roles in producing sound healthcare for their members.

ACCESS TO CARE

Missouri Care has made concerted efforts to ensure that members throughout the Central Region have adequate access to care. They have recruited additional hospitals and individual providers into their network. The health plan has participated in community events to promote preventive care and to ensure that members are aware of available services. This Region covers a diverse geographic area and the health plan exhibits an awareness of and commitment to resolving issues that are barriers to member services. The staff report that their ability to access behavioral health services for members, including their coordinated case management process, has ensured that members have greatly improved access to care.

TIMELINESS OF CARE

Missouri Care has developed procedures to ensure that policy is submitted in a timely manner and that all tracking tools are up-to-date. They are utilizing new case management software and systems tools to have the most accurate and up-to-date information available to support members in obtaining appropriate healthcare services in a timely manner. The health plan has engaged in a number of activities to ensure that organizational processes support the delivery of timely and quality healthcare.

RECOMMENDATIONS

1. Continue health plan development in the area of utilization of available data and member information. This will drive change and create opportunities for further service development.
2. Continue working with school districts and other community-based entities throughout the Central Region to contact members for educational opportunities.


3. Continue monitoring access to dental care and assist in recruitment of providers throughout the Central Missouri Region.

Appendices

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Appendix 1 – MCHP Orientation PowerPoint Slides



Orientation Agenda

- Introductions
- Orientation to Technical Methods and Objectives of Protocols
- Review of Information, Data Requests, and Timeframes
 - Performance Measures
 - Performance Improvement Projects
 - Encounter Data Validation
 - Compliance and Site Visits
- Closing Comments, Questions



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2007 External Quality Review for the Missouri MC+ Managed Care Program

Behavioral Health Concepts, Inc.
Performance Management Solutions Group
Amy McCurry Schwartz, Esq., MHSA
EQRO Project Director





Materials Provided


- Objectives and Technical Methods
 - Validation of Performance Measures
 - Validation of Encounter Data
 - Validation of Performance Improvement Projects
 - MCO Compliance
- Requests for information and data
- List of BHC contacts for each protocol
- Presentation



Overview

- Protocol Activities
- Information and Data Requests
- Contact Persons





Validation of Performance Measures

- HEDIS 2007 Measure Validation for MC+
 - Adolescent Well-Care Visits
 - Annual Dental Visit
 - Follow-up after Hospitalization for Mental Health Disorders
- Administrative
- Hybrid method
 - Review up to 30 medical records per measure sampled randomly



Submission Requirements for PM Validation

For each of the three measures:

- 2007 HEDIS Audit Report
- Baseline Assessment Tool for HEDIS 2007
- BHC EQRO Performance Measure Checklist (Method for Calculating HEDIS Measures; Table 1.xls)
- List of cases for denominator with all HEDIS 2007 data elements specified in the measures
 - Use an appropriate delimiter (e.g., @ for data that may contain commas or quotation marks).
 - Data layout for the files will be provided in the data request, this data layout must be used to ensure validity
 - Listing of fields names and descriptions of fields (i.e., data dictionary)
- List of cases for numerators with all HEDIS 2007 data elements specified in the measures
 - Use an appropriate delimiter (e.g., @ for data that may contain commas or quotation marks).
 - Data layout for the files will be provided in the data request, this data layout must be used to ensure validity
 - Listing of fields names and descriptions of fields (i.e., data dictionary)
- List of cases for which medical records were reviewed, with all HEDIS 2007 data elements specified in the measures
- BHC will request MCOs to gather up to 30 records per measure, based on a random sample, and MCO will send copies
- Sample medical record tools used for hybrid methods for HEDIS 2007 measures and instructions.
- All worksheets, memos, minutes, documentation, policies and communications within the MCO and with HEDIS auditors regarding the calculation of the selected measures
- Policies, procedures, data and information used to produce numerators and denominators
- Policies, procedures, data used to implement sampling
- Policies and procedures for mapping non-standard codes
- Others as needed



Validation of Encounter Data

- State encounter claim database
- Randomly selected encounters from medical claims, with service dates July 1, 2007 – September 30, 2007
- Review MCO supplied medical records for matching claims
- Match state and MCO claims databases for all encounters

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Sampling

1. All State Encounter
Claims,
July 1, 2007 – September 30,
2007

2. State Medical
Encounter
Claims
(N = 100 per
MCO)

3. All MCO encounter
claims,
July 1, 2007 – September
30, 2007
(N = 100 cases per MCO)



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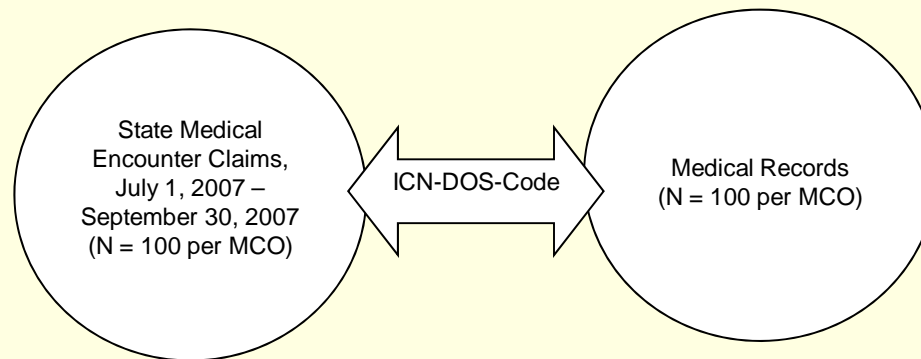
Analyses: 1

Critical fields will be examined for completeness (data in field), accuracy (correct type and length of data), and reasonableness (valid data for field) for each MCO. This will be conducted for all encounters in the specified time frame.

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Analyses: 2

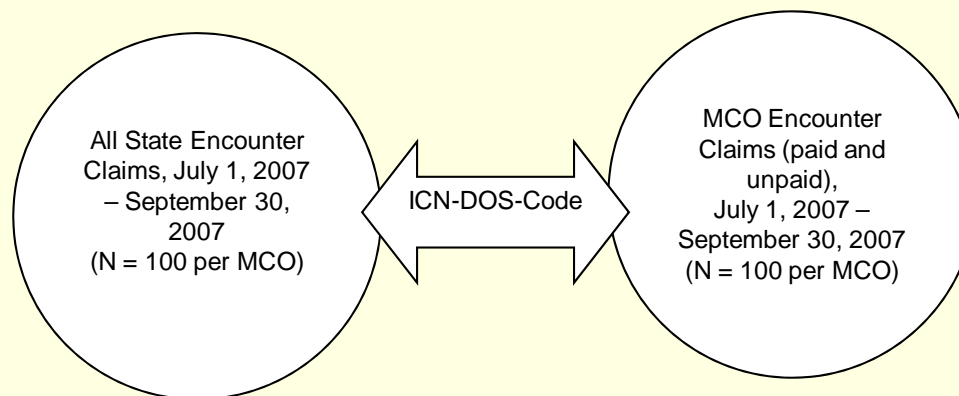
BHC will abstract the medical records and claims history/forms for each patient for the medical service provided during the entire time frame, enter into a database, and determine the rate(s) of matches, omissions and commissions between the medical record and the State encounter claims for each MCO. Matches will be cases that are consistent on patient ICN, date of service, and diagnosis or procedure code.



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Analyses: 3

BHC will determine the rate(s) of matches, omissions and errors between the State encounter claims and MCO encounter claims for each MCO for the sample of selected cases.





Encounter Data Validation Submission

- File 1: Provider mailing address and contact information for sampled claims (service dates July 1, 2007 to September 30, 2007). This will be used for validation of the State medical encounter claims database against the medical record.
- File 2: All inpatient encounters from July 1, 2007 to September 30, 2007 for selected MC+ members, with detailed provider information. This should be in the layout specified by BHC in the Encounter Data Submission Instructions.
- File 3: All outpatient encounters (Outpatient, Medical, Dental, and Home Health) from July 1, 2007 to September 30, 2007 for selected MC+ members, with detailed provider information. This should be in the layout specified by BHC in the Encounter Data Submission Instructions.
- File 4: All pharmacy encounters from July 1, 2007 to September 30, 2007 for selected MC+ members, with detailed provider information. This should be in the layout specified by BHC in the Encounter Data Submission Instructions.

NOTE: "unpaid claims" are those claims that the MCO denied for payment, unpaid claims do not include claims paid via a capitation plan.



Medical Record Reviews

- Encounter
 - Encounter sample provided to MCO
 - MCO to develop Files 1 (2 weeks from receipt of sample)
 - MCO to develop Files 2, 3, 4 (6 weeks from receipt of sample)
 - MCO to submit medical record request to providers (1 week from development of File 1)
 - MCOs to ensure providers supply medical records to BHC (4 weeks from submission of request to providers)
- HEDIS
 - Medical record samples requested from MCOs for 1 possible hybrid measure ($N \leq 30$ per measure; 4 weeks)



Medical Record Reviews (Cont'd)

- MCO will request and obtain Medical Records from providers
 - Letter from Sandra Levels
 - Instructions for submitting records
 - Encounter claim supporting information, dates, notes, claims information
 - Explanation of Confidentiality, storage of files
 - Explanation of HIPAA, Business Associate Agreement, Health Oversight Authority



Medical Record Reviews (Cont'd)

- Reviewed and abstracted by experienced and certified medical coders
- Standard abstraction tools
- Matching ICN, Date of Service, Diagnosis Code, Procedure Code



Validation of Performance Improvement Projects

- Two Performance Improvement Projects underway in 2007
 - One clinical
 - One non-clinical



Validation of Performance Improvement Projects and Submission Requirements

PIP Checklist Elements

- Project narratives, baseline measures, methods, interventions, and planned analyses. Examples of information are contained in the CMS protocol, Validation of Performance Measures^[1]
- Phase-in/timeframe for each phase of each PIP^[1]
- Problem identification
- Hypotheses
- Evaluation Questions
- Description of intervention(s)
- Methods of sampling, measurement
- Planned analyses
- Sample tools, measures, surveys, etc.
- Baseline data source and data
- Cover letter with clarifying information
- Raw data files (if applicable, on-site)
- Medical records or other original data sources (if applicable, on-site)
- Additional data as needed

^[1] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (2002) VALIDATING PERFORMANCE IMPROVEMENT PROJECTS A protocol for use in Conducting Medicaid External Quality Review Activities: Final Protocol Version 1.0 May 1, 2002





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MCO Compliance

- Enrollee Rights
- Grievances and Appeals
- Quality Improvement
- Submission Requirements TBD
 - Mental Health Case Management




Site Visits

- Target for July 2008
 - One to two weeks earlier than last year.
- MCO Compliance Reviews
- On-site activities
 - Performance Measure Validation
 - Performance Improvement Project Validation



Final Report

- MCO to MCO Comparisons:
 - Encounter data match/fault rates for diagnoses and procedures
 - Performance Measure audit findings and rates
 - Performance Improvement Project element compliance
 - MCO Compliance follow-up

 BHC Team and Coordination		
Protocol/ Activity	BHC Contact Behavioral Health Concepts, Inc. 2716 Forum Blvd., Suite 4a Columbia, MO 65203 Tel. 573-446-0405 Fax 573-446-1816	MCO Contact
Performance Measures (HEDIS 2007)	Amy McCurry Schwartz amccurry@pmsginfo.com	
Performance Improvement Projects	Amy McCurry Schwartz amccurry@pmsginfo.com Mona Prater Assistant, Project Director mprater@pmsginfo.com	
Encounter Data	Amy McCurry Schwartz amccurry@pmsginfo.com	
MCO Compliance	Mona Prater mprater@pmsginfo.com	
Site Visits	Amy McCurry Schwartz amccurry@pmsginfo.com Mona Prater mprater@pmsginfo.com	
Medical Records	Amy McCurry Schwartz amccurry@pmsginfo.com	

Appendix 2 – Performance Improvement Project Worksheets



Performance Improvement Project Validation Worksheet

Use this or similar worksheet as a guide when validating MCO/PIHP Performance Improvement Projects. Answer all questions for each activity. Refer to protocol for detailed information on each area.

ID of evaluator _____

Date of evaluation _____

Demographic Information

MCO/PIHP Name or ID _____

Project Leader Name _____

Telephone Number _____

Name of the Performance Improvement Project _____

Dates of Study _____

Date Study Initiated _____

Type of Delivery System (check all that apply)

☐ Staff Model☐ Network☐ Director IPA☐ IPA Organization☐ MCO☐ PIHP_____ Number of Medicaid Enrollees
in MCO or PIHP*_____ Number Medicare Enrollees in
MCO or PIHP_____ Number of Medicaid Enrollees
in the Study_____ Total Number of MCO or PIHP
Enrollees in Study

_____ Number of Members in Study

_____ Population of Members in
Sample Frame_____ Number of MCO/PIHP
primary care physicians_____ Number of MCO/PIHP
specialty physicians_____ Population of physicians in
sample frame

_____ Number of physicians in study

Note: DK = Don't Know; NA = Not Applicable

* Source: Missouri Medicaid Management Information System COLD Reports, State Session MPRI Screen, Revised June 25, 2004. Enrollment totals include enrollees with a future start date; 1115, 1915b, and Title XXI enrollees as of June 25, 2004.



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Activity 1: ASSESS THE STUDY METHODOLOGY**Step 1. Review the selected study topics(s)**

1.1 The topic was selected through data collection and analysis of comprehensive aspects of enrollee needs, care and services.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Topic or problem statement _____

Clinical

☐ Prevention of an acute or chronic condition
☐ Care for an acute or chronic condition

☐ High volume services
☐ High risk conditions

Nonclinical

☐ Process of accessing or delivering care

Comments

1.2 MCO's/PIHP's PIPs, over time, addressed a broad spectrum of key aspects of enrollee care and services.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Project must be clearly focused on identifying and correcting deficiencies in care or services rather than on utilization or cost alone.

Comments

1.3 MCO's/PIHP's PIPs over time, included all enrolled populations: i.e., did not exclude certain enrollees such as those with special health care needs.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Demographic description of MC+ population _____

Age _____
 Gender _____

Race _____

Payor _____

MC+ _____

Commercial _____

Comments

Step 2: Review the study question(s)

2.1 Study question(s) stated clearly in writing

☐ Met ☐ Partially met ☐ Not met

☐ Not applicable ☐ Unable to determine

Study question(s) as
stated in narrative:

Comments

Step 3: Review selected study indicators(s)

3.1 The study used objective, clearly defined, measurable indicators.

☐ Met ☐ Partially met ☐ Not met

☐ Not applicable ☐ Unable to determine

Indicators (list):

Comments

3.2 The indicators measured changes in health status, functional status or enrollee satisfaction; or process of care with strong association with improved outcomes.

☐ Met ☐ Partially met ☐ Not met

☐ Not applicable ☐ Unable to determine

Long term outcomes implied or stated:

☐ Yes ☐ No

Health status:

Satisfaction (members):

Functional status:

Satisfaction (providers):

Comments



Step 4: Review the identified study population

4.1 MCO/PIHP clearly defined all Medicaid enrollees to whom the study questions and indicators are relevant

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Demographic description of MC+ population sampled

Age _____ Race _____ MC+ _____
 Gender _____ Commercial _____

Did it include:

1115	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unable to determine	<input type="checkbox"/> NA
1915b	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unable to determine	<input type="checkbox"/> NA
Children in state custody	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unable to determine	<input type="checkbox"/> NA
Consent Decree (Western)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unable to determine	<input type="checkbox"/> NA

Comments

4.2 If the MCO/PIHP studied the entire population, did its data collection approach capture all enrollees to whom the study question applied?

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Methods of identifying participants

☐ utilization data ☐ referral
☐ self-identification ☐ other _____

Comments

Step 5: Review sampling methods

5.1 Sampling technique considered and specified the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of the error that will be acceptable.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Previous findings from:

☐ literature review ☐ baseline assessment of indices ☐ other _____

Comments



5.2 The MCO/PIHP employed valid sampling techniques that protected against bias.

The type of sampling used:

<input type="checkbox"/> Probability	<input type="checkbox"/> Nonprobability	<input type="checkbox"/> Random	<input type="checkbox"/> Simple	<input type="checkbox"/> Stratified
<input type="checkbox"/> Convenience	<input type="checkbox"/> Judgment	<input type="checkbox"/> Quota	<input type="checkbox"/> Cluster	

Comments:

5.3 Sample contained sufficient number of enrollees.

N of enrollees in sampling frame _____ N of sample _____

N of participants (i.e., return rate) _____

Comments:


Step 6: Review data collection procedures

6.1 Study design clearly specified the data to be collected.

<input type="checkbox"/> Met	<input type="checkbox"/> Partially met	<input type="checkbox"/> Not met
<input type="checkbox"/> Not applicable	<input type="checkbox"/> Unable to determine	

Comments:


6.2 The study design clearly specified the sources of data.		<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> Partially yes	<input type="checkbox"/> No/yes
		<input type="checkbox"/> Not applicable	<input type="checkbox"/> Unable to determine	
Source of data:				
<input type="checkbox"/> Member Comments	<input type="checkbox"/> Claims	<input type="checkbox"/> Provider	<input type="checkbox"/> Other	<input type="checkbox"/> _____
6.3 The study design specified a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply.		<input type="checkbox"/> Yes	<input type="checkbox"/> Partially yes	<input type="checkbox"/> No/yes
		<input type="checkbox"/> Not applicable	<input type="checkbox"/> Unable to determine	
Comments:				
6.4 The instruments for data collection provided for consistent, accurate data collection over the time periods studied.		<input type="checkbox"/> Yes	<input type="checkbox"/> Partially yes	<input type="checkbox"/> No/yes
		<input type="checkbox"/> Not applicable	<input type="checkbox"/> Unable to determine	
Instrument(s) used:				
<input type="checkbox"/> Survey	<input type="checkbox"/> Medical Record Abstraction Tool	<input type="checkbox"/> Other	<input type="checkbox"/> _____	
Comments:				



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6.5 The study design prospectively specified a data analysis plan.		<input type="checkbox"/> Met	<input type="checkbox"/> Partially met	<input type="checkbox"/> Not met
		<input type="checkbox"/> Not applicable	<input type="checkbox"/> Unable to determine	
Comments				
6.6 Qualified staff and personnel were used to collect the data.		<input type="checkbox"/> Met	<input type="checkbox"/> Partially met	<input type="checkbox"/> Not met
		<input type="checkbox"/> Not applicable	<input type="checkbox"/> Unable to determine	
Name _____ Title _____				
Role(s) of Project Leader _____				
Comments				
Step 7: Assess improvement strategies				
7.1 Reasonable interventions were undertaken to address causes/barriers identified through data analysis and QI processes undertaken.		<input type="checkbox"/> Met	<input type="checkbox"/> Partially met	<input type="checkbox"/> Not met
		<input type="checkbox"/> Not applicable	<input type="checkbox"/> Unable to determine	
Describe Intervention: _____				
Comments				



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Step 8: Review data analysis and interpretation of study results

NA if study is not yet complete

8.1 An analysis of the findings was performed according to data analysis plan.
☐ Met
 ☐ Partially met
 ☐ Not met
☐ Not applicable
 ☐ Unable to determine

Not met if study is complete and no indication of a data analysis plan (see step 6.5)

Comments

8.2 The MCO/PDHP presented numerical PIP results and findings accurately and clearly.
☐ Met
 ☐ Partially met
 ☐ Not met
☐ Not applicable
 ☐ Unable to determine
☐ Are tables and figures labeled?☐ Labeled clearly, accurately?

Comments

8.3 The analysis identified initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurement, and factors that threaten internal and external validity.
☐ Met
 ☐ Partially met
 ☐ Not met
☐ Not applicable
 ☐ Unable to determine

Indicate time periods of measurements:

Indicate statistical analyses used:

Indicate statistical significance level or confidence level used:

☐ 99%☐ 95%☐ Unable to determine

Comments



8.4 Analysis of study data included an interpretation of the extent to which its PIP was successful and follow-up activities.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Limitations described: _____

Conclusions regarding the success of the interpretation: _____

Recommendations for follow-up: _____

Comments

Step 9: Assess whether improvement is "real" improvement

Note: NA only if study period is not yet complete; otherwise "Unable to Determine" or "No"

9.1 The same methodology as the baseline measurement was used when measurement was repeated.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

Same source of data

☐ yes

☐ No

☐ Not applicable

☐ Unable to determine

Same method of data collection

☐ yes

☐ No

☐ Not applicable

☐ Unable to determine

Same participants examined

☐ yes

☐ No

☐ Not applicable

☐ Unable to determine

Same tool used

☐ yes

☐ No

☐ Not applicable

☐ Unable to determine

Comments

9.2 There was a documented, quantitative improvement in process or outcomes of care.

☐ Met ☐ Partially met ☐ Not met
☐ Not applicable ☐ Unable to determine

☐ increased

☐ decrease

Statistical significance _____

Clinical significance _____

Comments



9.3 The reported improvements in performance have "face" validity: i.e., the improvement in performance appears to be the result of the planned quality improvement intervention.

☐ Met ☐ Partially met ☐ Not met

☐ Not applicable ☐ Unable to determine

Degree to which the intervention was the reason for change:

☐ No relevance

☐ Small

☐ Fair

☐ High

Comments

9.4 There is statistical evidence that any observed performance improvement is true improvement

☐ Met ☐ Partially met ☐ Not met

☐ Not applicable ☐ Unable to determine

☐ Weak

☐ Moderate

☐ Strong

Comments

Step 10: Assess sustained improvement

10.1 Sustained improvement was demonstrated through repeated measurements over comparable time periods.

☐ Met ☐ Partially met ☐ Not met

☐ Not applicable ☐ Unable to determine

Comments



ACTIVITY 3: EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS: SUMMARY OF AGGREGATE VALIDATION FINDINGS AND RECOMMENDATIONS**Conclusions****Recommendations****Check one:**

- ☐ High confidence is reported ☐ Low confidence level is reported in MCO/PIHP PIP results
☐ Moderate confidence is reported MCO/PIHP PIP results ☐ Reported MCO/PIHP PIP results not credible
☐ Not Applicable, study not complete



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Appendix 3 – Performance Measures Request Documents**Performance Measure Validation****General Instructions****Mail Binder To:****Attn: External Quality Review Submission****Behavioral Health Concepts, Inc.****2716 Forum Blvd., Suite 4****Columbia, MO 65203****Due Date: January 28, 2008**

When applicable, submit one for each of the three measures:

- Follow-Up After Hospitalization for Mental Illness (FUH)
- Annual Dental Visit (ADV)
- Adolescent Well-Care Visits (AWC)

Unless otherwise indicated, please send all documents in hard copy, using the enclosed binder and tabs. If an item is not applicable or not available, please indicate this in the tab.

Electronic Data Submission Instructions:

- Data file formats all need to be ASCII, and readable in a Microsoft Windows environment. Please be sure to name data columns with the same variable names that appear in the following data layout descriptions.
- Make all submissions using compact disk (CD) formats. Data files submitted via e-mail will not be reviewed. Insure that files on the CD are accessible on a Microsoft Windows workstation prior to submitting.
- All files or CDs must be password protected. Do not write the password on the CD. Please email the password separately to amccurry@pmsginfo.com. Do not include the password anywhere on the CD, or in any correspondence sent with the CD.
- Use an appropriate delimiter (e.g., @, tab) for data that may contain commas or quotation marks, and please specify in a readme file or write on the CD what that delimiter is.
- Please ensure that date fields either contain a null value or a valid date.
- Files will be accepted only in the specified layout. Please avoid adding extra columns or renaming the columns we have requested.

There should be 3 separate files submitted for each measure:

File 1. Enrollment Data

File 2. Denominator and numerator file

File 3. Sample selection (cases that were selected for medical record review); this file is submitted for *Hybrid measures only*

The file layouts to be used for each measure are detailed on pages 2-7 of this document.

Please contact BHC prior to the submission deadline if you have any questions regarding these layouts or the data submission requirements, and we will be happy to assist you.

Follow-Up After Hospitalization for Mental Illness (FUH)

(Administrative Only)

File 1. Enrollment Data

Please provide all enrollment periods for each eligible Member to verify continuous enrollment and enrollment gaps.

Field Name	Acceptable Content	Description
MCHP	Any basic text and/or numbers	MO HealthNet Managed Care Health Plan name
MEASURE	FUH	Follow-Up After Hospitalization for Mental Illness
DCN	Whole numbers only	The Missouri Medicaid recipient identification number (not the MCOs internal tracking number)
MEMBR_FIRST	Any basic text	Member First Name
MEMBR_LAST	Any basic text	Member Last Name
DOB	Numbers only in a correct date format (ex. mm/dd/yyyy)	Member date of birth
ENROLL_FIRST	Numbers only in a correct date format (ex. mm/dd/yyyy)	First date of enrollment
ENROLL_LAST	Numbers only in a correct date format (ex. mm/dd/yyyy)	Last date of enrollment

File 2. Denominator and Numerator Data

Field Name	Acceptable Content	Description
MCHP	Any basic text and/or numbers	MO HealthNet Managed Care Health Plan name
MEASURE	FUH	Follow-Up After Hospitalization for Mental Illness
DCN	Whole numbers only	The Missouri Medicaid recipient identification number (not the MCOs internal tracking number)
MEMBR_FIRST	Any basic text	Member First Name
MEMBR_LAST	Any basic text	Member Last Name
DOB	Numbers only in a correct date format (ex. mm/dd/yyyy)	MMember date of birth
DISCHG_DATE	Numbers only in a correct date format (ex. mm/dd/yyyy)	Date of discharge from hospitalization applicable to this date of service
SER_DATE	Numbers only in a correct date format (ex. mm/dd/yyyy)	Date of service
SER_CODE	Any basic text and/or numbers	Code used to identify numerator event
CODING_TYPE	C, U, or H	Type of coding system: C=CPT Codes; U=UB-92 Revenue Codes; H=HCPCS Codes.
ADMIN_HIT	Y or N	Administrative numerator event (positive case "hit"): y=yes; n=no
EXCLUDE	Y or N	Was the case excluded from denominator Y=Yes; N=No
EXCLUDE_REASON	Any basic text and/or numbers	Reason for exclusion

Annual Dental Visit (ADV)

(Administrative Only)

File 1. Enrollment Data

Please provide all enrollment periods for each eligible MC+ Member to verify continuous enrollment and enrollment gaps.

Field Name	Acceptable Content	Description
MCHP	Any basic text and/or numbers	MO HealthNet Managed Care Health Plan name
MEASURE	ADV	Annual Dental Visit
DCN	Whole numbers only	The Missouri Medicaid recipient identification number (not the MCOs internal tracking number)
MEMBR_FIRST	Any basic text	Member First Name
MEMBR_LAST	Any basic text	Member Last Name
DOB	Numbers only in a correct date format (ex. mm/dd/yyyy)	Member date of birth
ENROLL_FIRST	Numbers only in a correct date format (ex. mm/dd/yyyy)	First date of enrollment
ENROLL_LAST	Numbers only in a correct date format (ex. mm/dd/yyyy)	Last date of enrollment

File 2. Denominator and Numerator Data

Field Name	Acceptable Content	Description
MCHP	Any basic text and/or numbers	MO HealthNet Managed Care Health Plan name
MEASURE	ADV	Annual Dental Visit
DCN	Whole numbers only	The Missouri Medicaid recipient identification number (not the MCOs internal tracking number)
MEMBR_FIRST	Any basic text	Member First Name
MEMBR_LAST	Any basic text	Member Last Name
DOB	Numbers only in a correct date format (ex. mm/dd/yyyy)	Member date of birth
SER_DATE	Numbers only in a correct date format (ex. mm/dd/yyyy)	Date of service
SER_CODE	Any basic text and/or numbers	Code used to identify numerator event
CODING_TYPE	C, H, or I	Type of coding system: C=CPT Codes; H=HCPCS/CDT-3 Codes*; I=ICD-9-CM Codes.
ADMIN_HIT	Y or N	Administrative numerator event (positive case "hit"): y=yes; n=no
EXCLUD	Y or N	Was the case excluded from denominator Y=Yes; N=No
EXCLUD_REASON	Any basic text and/or numbers	Reason for exclusion

* CDT is the equivalent dental version of the CPT physician procedural coding system.

Adolescent Well-Care Visits (AWC)

(Administrative or Hybrid)

File 1. Enrollment Data

Please provide all enrollment periods for each eligible MC+ Member to verify continuous enrollment and enrollment gaps.

Field Name	Acceptable Content	Description
MCHP	Any basic text and/or numbers	MO HealthNet Managed Care Health Plan name
MEASURE	AWC	Adolescent Well-Care Visits
DCN	Whole numbers only	The Missouri Medicaid recipient identification number (not the MCOs internal tracking number)
MEMBR_FIRST	Any basic text	Member First Name
MEMBR_LAST	Any basic text	Member Last Name
DOB	Numbers only in a correct date format (ex. mm/dd/yyyy)	Member date of birth
ENROLL_FIRST	Numbers only in a correct date format (ex. mm/dd/yyyy)	First date of enrollment
ENROLL_LAST	Numbers only in a correct date format (ex. mm/dd/yyyy)	Last date of enrollment

File 2. Denominator and Numerator Data

Field Name	Acceptable Content	Description
MCHP	Any basic text and/or numbers	MO HealthNet Managed Care Health Plan name
Measure	AWC	Adolescent Well-Care Visits
DCN	Whole numbers only	The Missouri Medicaid recipient identification number (not the MCOs internal tracking number)
MEMBR_FIRST	Any basic text	Member First Name
MEMBR_LAST	Any basic text	Member Last Name
DOB	Numbers only in a correct date format (ex. mm/dd/yyyy)	Member date of birth
SER_DATE	Numbers only in a correct date format (ex. mm/dd/yyyy)	Date of service
SER_CODE	Any basic text and/or numbers	Code used to identify numerator event
CODING_TYPE	C or I	Type of coding system: C=CPT Codes; I=ICD-9-CM Codes
DATA_SOURCE	A or MR	For Hybrid Method ONLY Please specify source of data: A = Administrative; MR = Medical Record Review
HYBRID_HIT	Y or N	For Hybrid Method ONLY Hybrid numerator event (positive event "hit"): y=yes; n=no
ADMIN_HIT	Y or N	Administrative numerator event (positive case "hit"): y=yes; n=no
NUMERATOR_ID	0 or 1	Please indicate if this case was counted toward: 0 = 0 visits numerator; 1 = 1 visit numerator;

Adolescent Well-Care (AWC)

(Administrative or Hybrid)

File 3. For Hybrid method ONLY - please provide a listing of the cases selected for medical record review. Use the following layout:

Field Name	Acceptable Content	Description
MCHP	Any basic text and/or numbers	MO HealthNet Managed Care Health Plan name
MEASURE	AWC	Adolescent Well-Care Visits
DCN	Whole numbers only	The Missouri Medicaid recipient identification number (not the MCOs internal tracking number)
MEMBR_FIRST	Any basic text	Member First Name
MEMBR_LAST	Any basic text	Member Last Name
DOB	Numbers only in a correct date format (ex. mm/dd/yyyy)	Member date of birth
MR_STATUS	R or NR or S	Medical record review status: R = reviewed; NR = not reviewed; S = substituted
PROVIDER_NAME	Any basic text and/or numbers	Primary Care Provider who supplied the record
PROVIDER_ID	Any basic text and/or numbers	Primary Care Provider identification number

Please see the Performance Measure Validation Submission Requirements and the Summary of Calculation Methods for Performance Measures.

2007 External Quality Review of the MO HealthNet Managed Care Program

Performance Measure Validation Submission Requirements

Instructions: The following listing includes relevant source data for the EQR process. Submit paper print outs or photocopied items in the

EQR 2007 binder supplied; use the associated tabs. Within each tab, include information specific for each of the three measures for the MO HealthNet Managed Care population. Some items may not apply. For example, if you do not use a HEDIS vendor and perform measure calculations on site, then you may not have documentation on electronic record transmissions. These items apply to processes, personnel, procedures, databases and documentation relevant to how the health plan complies with HEDIS measure calculation, submission and reporting.

If you have any questions about this request, contact Amy McCurry, EQRO Project Director,
amccurry@pmsginfo.com.

Key	
Check submitted	Use this field to indicate whether you have submitted this information. If you are not submitting the particular information, please indicate "NA". You may have submitted the content by other means either on the BAT or as part of some other documentation. If so, indicate "submitted", and reference the document (see below).
Name of Source Document	Please write the name of the document you are submitting for the item. If you are submitting pages from a procedure manual, indicate so by writing "HEDIS submission manual, pages xx – xx."
MCHP Comments	Use this space to write out any concerns you may have or any clarification that addresses any issues or concerns you may have regarding either the items requested or what you submitted in the response.

Reviewed By (BHC use)	This space will be for BHC staff use. The purpose will be for tracking what is received and what is not received. It will not indicate whether the documents actually address the specific issue.
-----------------------	---



Tab	HEDIS Performance Measure	Check if Submitted or NA	Name of Source Document	MCO Comments	Reviewed by (BHC use)
1.	HEDIS 2007 Data Submission Tool (MO DHSS 2007 Table B HEDIS Data Submission Tool) for all three measures for the MO HealthNet Managed Care Population only. <u>Do not include</u> other measures or populations.				
2.	2007 HEDIS Audit Report. This is the HEDIS Performance Audit Report for the MO HealthNet Managed Care Program product line and the three MO HealthNet measures to be validated (complete report). If the three measures to be validated were not audited or if they were not audited for the MO HealthNet Managed Care Program population, please send the report, as it contains Information Systems Capability Assessment information that can be used as part of the Protocol.				
3.	Baseline Assessment Tool (BAT) for HEDIS 2007. The information submitted for the BAT will include descriptions of the process for calculating measures for the MO HealthNet Managed Care Program population.				
4.	List of cases for denominator with all HEDIS 2007 data elements specified in the measures.				

Tab	HEDIS Performance Measure	Check if Submitted or NA	Name of Source Document	MCO Comments	Reviewed by (BHC use)
5.	List of cases for numerators with all HEDIS 2007 data elements specified in the measures, including fields for claims data and MOHSAIC, or other administrative data used. Please note that one of the review elements in the Protocol is: The "MCO/PIHP has retained copies of files or databases used for performance measure reporting, in the event that results need to be reproduced."				
6.	List of cases for which medical records were reviewed, with all HEDIS 2007 data elements specified in the measures. Based on a random sample, BHC will request health plans to gather a maximum of 30 records per measure and submit copies of the records requested to BHC.				
7.	Sample medical record tools used if hybrid method(s) were utilized for HEDIS 2007 Annual Dental Visit, Follow-Up After Hospitalization, or Well-Care Visits measures for the MO HealthNet Managed Care Program population; and instructions for reviewers.				

Tab	HEDIS Performance Measure	Check if Submitted or NA	Name of Source Document	MCO Comments	Reviewed by (BHC use)
8.	All worksheets, memos, minutes, documentation, policies and communications within the health plan and with HEDIS auditors regarding the calculation of the selected measures.				
9.	Policies, procedures, data and information used to produce numerators and denominators.				



Tab	HEDIS Performance Measure	Check if Submitted or NA	Name of Source Document	MCO Comments	Reviewed by (BHC use)
10.	<p>Policies, procedures, and data used to implement sampling (if sampling was used). At a minimum, this should include documentation to facilitate evaluation of:</p> <ul style="list-style-type: none"> a. Statistical testing of results and any corrections or adjustments made after processing. b. Description of sampling techniques and documentation that assures the reviewer that samples used for baseline and repeat measurements of the performance measures were chosen using the same sampling frame and methodology. c. Documentation of calculation for changes in performance from previous periods (if comparisons were made), including tests of statistical significance. 				
11.	Policies and procedures for mapping non-standard codes.				

Tab	HEDIS Performance Measure	Check if Submitted or NA	Name of Source Document	MCO Comments	Reviewed by (BHC use)
12.	Record and file formats and descriptions for entry, intermediate, and repository files.				
13.	Electronic transmission procedures documentation. (This will apply if the health plan sends or receives data electronically from vendors performing the HEDIS abstractions, calculations or data entry.)				
14.	Descriptive documentation for data entry, transfer, and manipulation of programs and processes.				
15.	Samples of data from repository and transaction files to assess accuracy and completeness of the transfer process.				

Tab	HEDIS Performance Measure	Check if Submitted or NA	Name of Source Document	MCO Comments	Reviewed by (BHC use)
16.	Documentation of proper run controls and of staff review of report runs.				
17.	Documentation of results of statistical tests and any corrections or adjustments to data along with justification for such corrections or adjustments.				
18.	Documentation of sources of any supporting external data or prior years' data used in reporting.				
19.	Procedures to identify, track, and link member enrollment by product line, product, geographic area, age, sex, member months, and member years.				

Tab	HEDIS Performance Measure	Check if Submitted or NA	Name of Source Document	MCO Comments	Reviewed by (BHC use)
20.	Procedures to track individual members through enrollment, disenrollment, and possible re-enrollment.				
21.	Procedures used to link member months to member age.				
22.	Documentation of "frozen" or archived files from which the samples were drawn, and if applicable, documentation of the MCO's/PIHP's process to re-draw a sample or obtain necessary replacements.				
23.	Procedures to capture data that may reside outside the MCO's/PIHP's data sets (e.g. MOHSAIC).				

Tab	HEDIS Performance Measure	Check if Submitted or NA	Name of Source Document	MCO Comments	Reviewed by (BHC use)
24.	Policies, procedures, and materials that evidence proper training, supervision, and adequate tools for medical record abstraction tasks. (May include training material, checks of inter-rater reliability, etc.)				



Performance Measures to be Calculated for MO HealthNet Members			
METHOD FOR CALCULATING HEDIS 2007 PERFORMANCE MEASURES			
<i>Please complete this form and place in the HEDIS 2007 section of the binder supplied by BHC. Please direct any questions to Amy McCurry or Stephani Worts.</i>			
MCHP			
Date Completed			
Contact Person			
Phone			
Fax			
NCQA Accredited for MC+ Product (Yes/No)			
Certified HEDIS Software Vendor and Software			
Record Abstraction Vendor			
What was the reporting Date for HEDIS 2007 Measures?			
What was the Audit Designation (Report/No Report/Not Applicable)?			
Was the measure publicly Reported (Yes/No)?			
Did denominator include members who switched MCHPs (Yes/No)?			
Did denominator include members who switched product lines (Yes/No)?			
Did the denominator include 1115 Waiver Members (Yes/No)?			
Were proprietary or other codes (HCPC, NDC) used?			
Were exclusions calculated (Yes/No)?			
On what date was the sample drawn?			
Were exclusions calculated (Yes/No)?			
How many medical records were requested?			
How many medical records were received?			
How many medical records were substituted due to errors in sampling?			
How many medical records were substituted due to exclusions being measured?			

Appendix 4 – Performance Improvement Project Request Documents

Performance Improvement Project Validation

General Instructions

Mail All Required Information to:

**Attn: External Quality Review Submission
Behavioral Health Concepts, Inc.
2716 Forum Blvd., Suite 4
Columbia, MO 65203**

Due in BHC Office no later than: 3:00 p.m., March 3, 2008

Please refer to Performance Improvement Project Validation Submission Requirements and the health plan Performance Improvement Project Summary.

2007 External Quality Review of the MO HealthNet Managed Care Program

Performance Improvement Project Validation Submission Requirements

Instructions:

The following listing includes relevant source data for the EQR process. Submit paper printouts or photocopied items using the associated tabs for each of the two Performance Improvement Project selected for review from the topics submitted. Please refer to the enclosed health plan Performance Improvement Project Summary. Place information behind the associated cover sheet and complete the form below. You may also mark PIP sections if desired. Use the separate cover sheets and summary sheets for each PIP.

If you have any questions about this request, contact Amy McCurry, EQRO Project Director, amccurry@pmsginfo.com.

Key	
Check submitted	Use this field to indicate whether you have submitted this information. If you are not submitting the particular information, please indicate "NA". You may have submitted the content by other means or as part of some other documentation. If so, indicate "submitted", and reference the document (see below).
Name of Source Document	Please write the name of the document you are submitting for the item. If you are submitting pages from a procedure manual, indicate in writing.
Health Plan Comments	Use this space to write out any concerns you may have or any clarification that addresses any issues or concerns you may have regarding either the items requested or what you submitted in the response.

Reviewed By (BHC
use)

This space will be for BHC staff use. The purpose will be for tracking what is received and what is not received. It will not indicate whether the documents actually address the specific issue.



Name of
PIP: _____

Tab		✓ if Submitted or NA	Name of Source Document	MCO Comments	Reviewed by (BHC use)
1.	Cover letter with clarifying information (optional)				
2.	<p>Project narratives, baseline measures, methods, interventions, and planned analyses. Examples of information are contained in the CMS protocols, Validation of Performance Improvement Projects and Conducting Performance Improvement Projects. We will be looking for the following information in the Performance Improvement Project descriptions.</p> <ul style="list-style-type: none"> a. Name and date of inception for each project. b. Problem identification, including data collection and analysis justifying the chosen topic based on enrollee needs, care and services. c. Hypotheses d. Study question evaluation e. Selected study indicators f. Description of intervention(s) g. Methods of sampling, measurement h. Data collection procedures i. Planned analyses j. Sample tools, measures, surveys, etc. k. Baseline data source and data 				

	<ul style="list-style-type: none">l. Improvement strategiesm. Assessment of improvement and sustainability				
--	---	--	--	--	--

Note: BHC may request raw data files, medical records, or additional data.



Appendix 5 – Performance Measures Worksheets

Final Performance Measure Validation Worksheet: HEDIS 2007 Follow-up After Hospitalization for Mental Illness

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who were seen on an outpatient basis or were in intermediate treatment with a mental health provider.

Element	Specifications	Rating	Comments
Documentation			
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.			
Eligible Population			
Age	6 years and older as of date of discharge.		
Enrollment	Date of discharge through 30 days.		
Gap	No gaps in enrollment.		
Anchor date	None.		
Benefit	Medical and mental health (inpatient and outpatient)		
Event/diagnosis	Discharged from an inpatient setting of an acute care facility (including acute care psychiatric facilities) with a discharge date occurring on or before December 1 of the measurement year and a principal ICD-9-CM diagnosis code indicating a mental health disorder specified in Table FUH-A. The MCO should not count discharges from nonacute care facilities (e.g., residential care or rehabilitation stays).		
Sampling			
Sampling was unbiased.			
Sample treated all measures independently.			
Sample size and replacement methods met specifications.			

Numerator			
Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCOs network) are complete and accurate.			
Calculation of the performance measure adhered to the specification for all components of the numerator of the performance measure.			
Documentation tools used were adequate.			
Integration of administrative and medical record data was adequate.			
The results of the medical record review validation substantiate the reported numerator.			
Denominator			
Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.			
Reporting			
State specifications for reporting performance measures were followed.			
Estimate of Bias			
What range defines the impact of data incompleteness for this measure?	0 - 5 percentage points		
	> 5 - 10 percentage points		
	> 10 - 20 percentage points		
	> 20 - 40 percentage points		
	> 40 percentage points		
	Unable to determine		
What is the direction of the bias?	Underreporting		
	Overreporting		
Audit Rating			

Fully Compliant = Measure was fully compliant with State specifications.

Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate.

Not Valid = Measure deviated from State specification such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required.

Not Applicable = No MC+ Members qualified

Note: 2 = Met; 0 = Not Met

**Final Performance Measure Validation Worksheet: HEDIS 2007
Adolescent Well-Care Visits**

The percentage of enrolled members who were 12 - 21 years of age and who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN during the measurement year.

Element	Specifications	Rating	Comments
Documentation			
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.			
Eligible Population			
Age	12 -21 years as of December 31, 2006.		
Enrollment	Continuous during 2006.		
Gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for an MC+ beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage.		
Anchor date	Enrolled as of December 31, 2006.		
Benefit	Medical		
Event/diagnosis	None		
Sampling			
Sampling was unbiased.			
Sample treated all measures independently.			
Sample size and replacement methods met specifications.			
Numerator			
Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCOs network) are complete and accurate.			
Calculation of the performance measure adhered to the specification for all components of the numerator of the performance measure.			
Documentation tools used were adequate.			
Integration of administrative and medical record data was adequate.			

The results of the medical record review validation substantiate the reported numerator.			
Denominator			
Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.			
Reporting			
State specifications for reporting performance measures were followed.			
Estimate of Bias			
What range defines the impact of data incompleteness for this measure?	0 - 5 percentage points		
	> 5 - 10 percentage points		
	> 10 - 20 percentage points		
	> 20 - 40 percentage points		
	> 40 percentage points		
	Unable to determine		
What is the direction of the bias?	Underreporting		
	Overreporting		
Audit Rating			

Fully Compliant = Measure was fully compliant with State specifications.

Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate.

Not Valid = Measure deviated from State specification such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required.

Not Applicable = No MC+ Members qualified

Note: 2 = Met; 0 = Not Met

Final Performance Measure Validation Worksheet: HEDIS 2007 Annual Dental Visit

The percentage of enrolled MC+ Managed Care Program Members who were 2 -21 years of age who had at least one dental visit during the measurement year. This measure applies only if dental care is a covered benefit in the MCO's Medicaid contract.

Element	Specifications	Rating	Comments
Documentation			
Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.			
Eligible Population			
Age	2 -21 years of age as of December 31, 2006. The measure is reported for each of the following age stratifications and as a combined rate: * 2 -3 year-olds * 4 -6 year-olds * 7-10 year-olds * 11 - 14 year-olds * 15 - 18 year-olds * 19 - 21 year-olds		
Enrollment	Continuous during 2006		
Gap	No more than one gap in enrollment of up to 45 days during 2006. To determine continuous enrollment for an MC+ beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage.		
Anchor date	Enrolled as of December 31, 2006		
Benefit	Medical		
Event/diagnosis	None		
Sampling - Not Applicable to this measure, calculated via Administrative calculation methodology only			

Numerator			
Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCOs network) are complete and accurate.			
Calculation of the performance measure adhered to the specification for all components of the numerator of the performance measure.			
Denominator			
Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.			
Reporting			
State specifications for reporting performance measures were followed.			
Estimate of Bias			
What range defines the impact of data incompleteness for this measure?	0 - 5 percentage points		
	> 5 - 10 percentage points		
	> 10 - 20 percentage points		
	> 20 - 40 percentage points		
	> 40 percentage points		
	Unable to determine		
What is the direction of the bias?	Underreporting		
	Overreporting		
Audit Rating			

Fully Compliant = Measure was fully compliant with State specifications.

Substantially Compliant = Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate.

Not Valid = Measure deviated from State specification such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required.

Not Applicable = No MC+ Members qualified

Note: 2 = Met; 0 = Not Met

Appendix 6 – Encounter Data Minimum Criteria

Recommended Encounter Data Validation Criteria

Data Element	Expectation	Validity Criteria
Enrollee ID	Should be valid as found in the State's eligibility file.	100% valid
Principal Diagnosis	Well-coded lead-related diagnoses (or well-child visit)	> 90% non-missing and valid codes.
Date of Service	Dates should be evenly distributed across time	If looking at a full year of data 5-7% of the records should be distributed across each month.
Unit of Service (Quantity)	The number should be routinely coded.	98% non-zero <70% should be one if CTP code in range of 99200-99215, 99241-99291
Procedure Code	This is a critical element and should always be coded. Will be assessed only for presence of code except for lead-related codes which will be validated with medical records.	99% present (not zero, blank, 8- or 9-filled). 100% should be valid, State-approved codes. There should be a wide range of procedures with the same frequency as previously encountered.

Source: Medstat (1999). A Guide for States to Assist in the Collection and Analysis of Medicaid Managed Care Data:: Second Edition

Appendix 7 – Encounter Data Request Documents

Encounter Data Validation Submission Instructions

Mail To:

Behavioral Health Concepts, Inc.
Attn: Amy McCurry Schwartz
2716 Forum Blvd., Suite 4
Columbia, MO 65203

Label the package **CONFIDENTIAL**

Due Date (due in BHC's offices by close of business): Friday, May 4, 2007

General data submission instructions

Data file formats all need to be ASCII, and readable in Microsoft Windows environment. Use an appropriate delimiter (e.g., @) for data that may contain commas or quotation marks. Ensure that date fields either contain a null value or a valid date. Make all submissions using compact disk (CD) formats and mail it to BHC, Inc. No files will be accepted via e-mail. Ensure that files on the CD are accessible on a Microsoft Windows workstation prior to submitting.

Specific data submission instructions

Please provide documentation for each electronic file being submitted.

Encounter Data Request

There should be 4 files submitted to BHC:

1. File 1: Mailing address and contact of the provider associated with each Internal Control Number (ICN) for sampled claims (service dates July 1, 2006 to September 30, 2006). Although MC+ Managed Care Organizations will be doing medical record requests, BHC need to have detailed provider information for tracking purposes.
2. File 2: All inpatient encounters from July 1, 2006 to September 30, 2006 for selected recipients, with detailed provider information. Please submit file using the following layout.

Field Name	Content Description
ICLAIM_TYPE	Claim type: I = Inpatient
ICLAIM_STATUS	P=Paid U=Unpaid D=Denied
IICN	State assigned Internal Control Number (ICN)
IPaid-AMT	This field indicates the amount of money paid to the hospital for the billed services.
IRECIP-ID	The Missouri Medicaid recipient identification number.
ILAST	Recipient last name
IFIRST	Recipient first name
IACCT_NUM	The recipient's account number used by the doctor's office.
IADMIT_TYPE	Admission Type The only valid values are: 1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn

	9 = Information Not Available
IADM_DT	The date the recipient was admitted to the hospital. This date cannot exceed the current date.
IDSCH_DT	The date the recipient was discharged from the hospital. If the patient is still in the hospital, the latest date of service that applies to the claim.
IBILL_TYPE	<p>Valid bill type codes are:</p> <p>Inpatient</p> <p>11x</p> <p>12x</p> <p>18x</p> <p>Outpatient</p> <p>13x</p> <p>14x</p> <p>71x (Rural Health)</p> <p>81x (Hospice)</p> <p>82x (Hospice)</p> <p>Home Health</p> <p>30x</p> <p>31x</p> <p>32x</p> <p>33x</p> <p>34x</p> <p>35x</p> <p>36x</p> <p>37x</p> <p>38x</p> <p>39x</p>
ISTAT	The code that represents the condition under which the recipient was discharged.

	<p>01 Home</p> <p>02 Hospital</p> <p>03 Skilled Nursing Facility (SNF)</p> <p>04 Intermediate Care Facility (ICF)</p> <p>05 Institution (Inst)</p> <p>06 Home Health Agency (HHA)</p> <p>07 Left</p> <p>08 Other</p> <p>20 Death</p> <p>30 Still A Patient</p> <p>50 Discharge from Hospice to Home</p> <p>51 Discharge from Hospice to Another Medical Facility</p> <p>62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital</p> <p>64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare</p> <p>65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital</p>
I PROV_NUM	The Health Plan's 9-digit provider number.
I PRIM_DX	The recipient's primary diagnosis. Decimal points are implied.
IDX_2	Second diagnosis. Decimal points are implied.
IDX_3	Third diagnosis. Decimal points are implied.
IDX_4	Fourth diagnosis. Decimal points are implied.
IDX_5	Fifth diagnosis. Decimal points are implied.
I KEY	<p>A code that indicates the patient has other insurance that may or may not be reflected on the claim. Valid values are:</p> <p>1 = Yes, patient has other insurance.</p> <p>2 = Yes, patient has other insurance not</p>

	reflected on this bill. 3 = No, patient does not have other insurance.
IFDT_SVC	The date that the billing period begins.
ILDT_SVC	The date that the billing period ends.
IREVENUE_CD	The three-digit code from 100 to 999 that represents the services that are billed on this particular line item. The combined total number of accommodation and ancillary services billed cannot exceed 28 lines per claim. Accommodation revenue codes range from 10X through 21X. Ancillary revenue codes range from 22X through 99X. NOTE: Emergency Room (rev 450 and 459) and Ambulance (rev 540 to 549) may only be billed as inpatient if the patient is admitted to the hospital.
IUNITS_SVC	The number of days per room rate for both covered and non-covered accommodations (revenue codes 100 through 239). Whole numbers only are accepted for the days.

3. File 3: All outpatient encounters (Outpatient, Medical, Dental, and Home Health) from July 1, 2006 to September 30, 2006 for selected recipients, with detailed provider information. Please submit file using the following layout.

Field Name	Content Description
OCLAIM_TYPE	O=Outpatient M=Medical L=Dental H=Home Health
OCLAIM-STATUS	Claim Type: O, M, L, H P=Paid U=Unpaid D=Denied
OICN	State assigned Internal Control Number (ICN)
OPAID_AMT	Claim Type O, M, L, H This field is informational only and reflects what FFS would pay.
ORECIP_ID	Claim Type: O, M, L, H

	The Missouri Medicaid recipient identification number.
OLAST	Claim Type: O, M, L, H Recipient last name
OFIRST	Claim Type: O, M, L, H Recipient first name
OACCT_NUM	Claim Type: O, M, L, H The recipient's account number used by the doctor's office. This field may be left blank or used for other purposes, such as the Health Plan Claim Internal Control Number.
OPROV_NUM	Claim Type: O, M, L, H The Health Plan's 9 digit provider number.
OPRIM_DX	Claim Type: O, M, L, H The ICD-9 diagnosis code of the recipient's diagnosis. Any decimal point needed in the diagnosis code is implied and should not be included.
ODX_2	Claim Type: O, M, L, H Second diagnosis. The ICD-9 diagnosis code of the recipient's diagnosis. Any decimal point needed in the diagnosis code is implied and should not be included.
ODX_3	Claim Type: O, M, L, H Third diagnosis. The ICD-9 diagnosis code of the recipient's diagnosis. Any decimal point needed in the diagnosis code is implied and should not be included.
ODX_4	Claim Type: O, M, L, H Fourth diagnosis. The ICD-9 diagnosis code of the recipient's diagnosis. Any decimal point needed in the diagnosis code is implied and should not be included.
ODX_5	Claim Type: O, M, L, H Fifth diagnosis. The ICD-9 diagnosis code of the recipient's diagnosis. Any decimal point needed in the diagnosis code is implied and should not be included.
O_KEY	Claim Type: O, M, L, H A code that indicates the patient has other insurance that may or may not be reflected on the claim. Valid values are: 0 = No, patient does not have other insurance. 1 = Yes, patient has other insurance. 2 = Yes, patient has other insurance not reflected on this bill.
OFIRSTDT_SVC	Claim Type: O, M, L, H This is the first date the service was performed. This

	date cannot exceed the current date.
OLASTDT_SVC	Claim Type: O, M, L, H This is the last date the service was performed. This date cannot exceed the current date.
OPLACE_SVC	Claim Type: M, L C-14 PLACE OF SERVICE 03 School 04 Homeless Shelter 05 Indian Health Service Free-Standing Facility 06 Indian Health Service Provider-Based Facility 07 Tribal 638 Free-Standing Facility 08 Tribal 638 Provider-Based Facility 11 Office 12 Home 13 Assisted Living Facility 14 Group Home 15 Mobile Unit 20 Urgent Care Facility 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room - Hospital 24 Ambulatory Surgical Center 25 Birthing Center 26 Military Treatment Facility 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Ambulance - Land 42 Ambulance - Air or Water 49 Independent Clinic 50 Federally Qualified Health Center (FQHC) 51 Inpatient Psychiatric Facility 52 Psychiatric Facility - Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility/Mentally Retarded 55 Residence Substance Abuse Treatment Facility 56 Psychiatric Residential Treatment Facility 57 Non-Residential Substance Abuse Treatment Facility 60 Mass Immunization Center 61 Comprehensive Inpatient Rehabilitation Facility 62 Comprehensive Outpatient Rehabilitation Facility 65 End Stage Renal Disease Treatment Facility 71 State or Local Public Health Clinic 72 Rural Health Clinic 81 Independent Laboratory 97 Parochial/Private Schools 98 Schools 99 Other Unlisted Facility Claim Type: O, H

	Not applicable
OUTPAT-UNITS-SVC	Claim Type: O, M, L, H The number of units of services performed. Whole numbers only.
ODTL-PROC	Claim Type: M, L, H The procedure code that represents the service preformed. Claim Type: O For outpatient claims, a procedure code is required only when the revenue code range for outpatient services is 300 through 319. This revenue code range represents laboratory services. The appropriate CPT procedure code range for laboratory services is 80048 through 89399. All other outpatient services must be designated by revenue code.
ODTL-PROC-MOD-P	Claim Type: O, M, L, H The 2-digit modifier that applies to the service provided.
ODTL-PROC-MOD-I	Claim Type: O, M, L, H The 2-digit modifier that applies to the service provided.
ODTL-DIAG-CODE	Claim Type: O, M, L, H The diagnosis code of the recipient's diagnosis. Decimal points are implied.
OREVENUE_CD	Claim Type: O The three digit code from 100 to 999 which represents the services that are billed on this particular line item. A revenue code is required on all Outpatient claims. For those revenue codes representing lab services (300-319), a procedure code must also be submitted. Claim Type: M, L, H Not applicable

4. File 4: All pharmacy encounters from July 1, 2006 to September 30, 2006 for selected recipients, with detailed provider information. Please submit file using the following layout.

Field Name	Content Description
PH_TRANSACTION-CD	This field shows the number of claims being billed on the record. Valid values are: 01 - 1 Claim 02 - 2 Claims 03 - 3 Claims 04 - 4 Claims (maximum)
PHCLAIM_STATUS	P=Paid U=Unpaid D=Denied
PHICN	State assigned Internal Control Number (ICN)
PH_PROV-NUM	The Health Plan's 9-digit provider number
PH_NABP-NUM	This field will always contain the 7-digit National

	Association of Boards of Pharmacy (NABP) identification number assigned to the pharmacy. The NABP number must be in the first 7 positions of the 9-digit field (left justified).
PHRECIP_ID	The Missouri Medicaid recipient identification number.
PHKEY	A code that indicates the patient has other insurance that may or may not be reflected on the claim. Valid values are: 0 = No, patient does not have other insurance. 1 = Yes, patient has other insurance. 2 = Yes, patient has other insurance not reflected on this bill.
PH_FIRST-DT-SVC	The dispense date.
PH_LAST	Entire name may be entered. Only the first two letters of the recipient's last name and the first letter of the recipient's first name will be verified against the recipient's Medicaid enrollment records. The plan must send a minimum of two characters for the last name and one character for the first name.
PH_FIRST	Entire name may be entered. Only the first two letters of the recipient's last name and the first letter of the recipient's first name will be verified against the recipient's Medicaid enrollment records. The plan must send a minimum of two characters for the last name and one character for the first name.
PH_PRESCRIP-NUM	The prescription number of the prescription filled or refilled.
PHREFILL-IND	The only valid values are: Original - 00 (zero) Refill - 01-99
PHDRUG-QTY	The metric or non-metric quantity of the drug being dispensed. For example: A quantity of 100 would be 0100.
PHDAYS-SUPPLY	The estimated number of days the dispensed amount represents. A days supply greater than 365 is invalid.
PHCOMPOUND-IND	An indicator identifying the prescription as a non-compound or as an ingredient of a compound prescription. A value of '0' or '1' is used to indicate non-compound prescriptions or the FIRST ingredient of a compound prescription. A value of '2' is used to indicate any additional ingredients of a compound prescription.
PHARM-DRUG-NDC-CODE	The National Drug Code designated for the drug dispensed. The field is 5-4-2 format no hyphens or spaces
PHPROV-NUM	The Medicaid, DEA number, or name of the prescribing physician. If not available, enter the dispensing pharmacy NABP number unless you are a pharmacy having FQHC status.

PHEPSDT-IND	A code indicating whether or not a drug was dispensed to a recipient under the Early Periodic Screening and Diagnostic Treatment (EPSDT) program. Y = yes
-------------	---

Appendix 8 – Medical Record (MR) Request Letters
PERFORMANCE MEASURES MR REQUEST LETTER



Behavioral Health Concepts, Inc.

Victoria Park, 2716 Forum Blvd., Suite 4, Columbia, MO 65203

(573) 446-0405
(573) 446-1816 (fax)
(866) 463-6242 (toll-free)
www.bhcinfo.com

February 13, 2008

**Subject: 2007 External Quality Review Performance Measure Validation
Protocol Medical Records Request (hybrid methodology only).**

Due Date: March 24, 2008

Dear <....>,

We have reviewed <MCHP Name>'s HEDIS 2007 Adolescent Well Care Measure.

Please find attached a file containing a listing of the cases related to this HEDIS Measure that have been selected for medical record review. Behavioral Health Concepts, Inc. (BHC) requests copies of all medical records for these sampled cases. Each medical record supplied should contain all the information that contributed to the numerator for the given HEDIS 2007 Measure. Please forward copies of these medical records to BHC at the address listed above, and mark the package as confidential.

If you have any questions, please contact BHC's External Quality Review team at (573) 446-0405 or via e-mail: amccurry@bhcinfo.com

Thank you,

A handwritten signature in black ink, appearing to read "Amy McCurry Schwartz".

Amy McCurry Schwartz
EQRO Project Director

Attachment:



Performance Management Solutions Group
A division of Behavioral Health Concepts, Inc.

- 1) File containing a sample of cases for medical record review

cc: Ms. Susan Eggen, Assistant Deputy Director, MO HealthNet Division,
Missouri Department of Social Services

ENCOUNTER DATA MR REQUEST LETTER



Behavioral Health Concepts, Inc.

Victoria Park, 2716 Forum Blvd., Suite 4, Columbia, MO 65203

(573) 446-0405
(573) 446-1816 (fax)
(866) 463-6242 (toll-free)
www.bhcinfo.com

March 3, 2008

Re: 2007 External Quality Review Encounter Data Validation Protocol

Dear MO HealthNet Managed Care Health Plan Encounter Data
Validation Contact:

As discussed with MCO staff during the 2007 EQR orientation meeting over
teleconference, BHC is requesting the following information for Encounter
Data Validation from each health plan:

5. File 1: Mailing address and contact information of
provider associated with each Internal Control
Number (ICN) for the sampled claims (service dates
July 1, 2007 to September 30, 2007). BHC requires this
information for tracking purposes. **Due date: March
17, 2008.**

Enclosed is a CD-ROM containing a file of the sample of encounters. This
file contains claim ICNs (Internal Control Number) and patient identifying
information. Please use this sample to request medical records from
providers. The password for this CD-ROM is contained in the email I sent to
you with the subject line: 2007 Encounter Data Request.

We are allowing up to seven business days for preparation of the medical
record requests. The requests must be submitted to providers by March
24, 2008. This will allow the providers 5 weeks to gather records. Providers
should supply records directly to BHC, Inc. by **April 28, 2008.**

MO HealthNet Managed Care Health Plans are extended an additional
week to submit records that are collected from providers. Records not
received by **May 5, 2008** will be considered undocumented encounters.
Please be advised that BHC and/or MO HealthNet Division do not provide
reimbursement for the cost of photocopying or mailing records.



During the past four years BHC provided a status report to MCHPs indicating the submission rate of records during the collection process. This practice is intended to facilitate a higher return rate. In order to provide this service, BHC must obtain requested provider information. Please return provider contact information to BHC, in the requested format, by **March 17, 2008.**

To assist with the medical record request process, we have also enclosed medical records submission instructions, and a letter from Sandra Levels detailing information regarding federal and state requirements for adherence to HIPAA and the External Quality Review.

If you have any questions, please contact BHC's External Quality Review team at 573-446-0405.

Thank you,



Amy McCurry Schwartz, Esq., MHSA
EQRO Project Director

Encl:

1. Encounter Data Validation Submission Instructions
2. Medical Records Submission Instructions
3. Letter from Sandra Levels
4. CD-ROM with sample of encounters for encounter data validation

CC:

Ms. Susan Eggen, Assistant Deputy Director, MO HealthNet Managed Care, Missouri
Department of Social Services, Division of MO HealthNet

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Appendix 10 – Abstraction Tools

ENCOUNTER DATA MEDICAL RECORD ABSTRACTION TOOL

Medical Record Abstraction Tool

Record ID Primary Key
Patient Name OUTPAT_RECIP_LAST_NAME OUTPAT_RECIP_FIRST_NAME
Date of Birth OUTPAT_RECIP_BIRTHDATE
Patient DCN OUTPAT_PROCESSED_RECIP_ID
Provider Name FIELD
Clinic Name FIELD
Clinic Address
First Date of Service FIELD

Abtractor Initials

m	m	d	d	y	y	y	y
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Date of abstraction

Data entry operator initials

h	h	m	m
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Start Time

Examine only the information provided in physician and professional documentation. **DO NOT** use the CMS-1500, any claim forms, or any claim histories.

Medical Record									
Element	Comparison							Match	Error Type
Date of Service	OUTPAT_FIRST_DT_SVC							0 = No 1 = Yes	Code only 1, 8, 9, or 0
	m	m	d	d	y	y	y		
Missing = 99999999 Comment (Required if Error Type = Other)									

Primary Diagnosis		OUTPAT_DX_1					0 = No 1 = Yes	Code only 1, 3, 8, 9, or 0
Decimal is implied. Start at left. If only 3 or 4 digits, leave the right spaces blank.								
Missing = 99999								
Comment (Required if Error Type = Other)								
Primary Diagnosis Description		DX_DESCRIPTION					0 = No 1 = Yes	Code only 8, 9, or 0
Comment (Add description from medical record; Required if Error Type = Other)								

Patient Name OUTPAT_RECIP_LAST_NAME OUTPAT_RECIP_FIRST_NAME
Date of Birth OUTPAT_RECIP_BIRTHDATE
Patient DCN OUTPAT_PROCESSED_RECIP_ID

Element	Code						
Procedure Code	To be coded by reviewer						
Decimal is implied. Start at left. If only 3 or 4 digits, leave the right spaces blank.							
Not Enough Information = 22222							
Comment (Required if Error Type = Other)							
Procedure Description	To be coded by reviewer						
Comment (Add description from medical record; Required if Error Type = Other)							

Referrals Documented in the Medical Record (check all that apply; only if not related to the claim validated)	
<input type="checkbox"/>	None (0)
<input type="checkbox"/>	Laboratory (1)
<input type="checkbox"/>	Pharmacy (2)
<input type="checkbox"/>	Specialist (3)
<input type="checkbox"/>	Radiology (4)
<input type="checkbox"/>	Other (5)
List _____	

See next page for the procedure code and procedure code description to be validated.

Does the medical record documentation adequately support the procedure code and description?

- ☐ Yes (1)
☐ No (0)

If no, Reason (check only one):

Not enough information (e.g., the date of service and information are present, but there is not enough

- ☐ information to make a determination) (1)
☐ Upcoded (2)
☐ Incorrect (3)
☐ Missing (9)
☐ Other (4) _____

Comment

Patient Name
Date of Birth
Patient DCN

OUTPAT_RECIP_LAST_NAME
OUTPAT_RECIP_BIRTHDATE
OUTPAT_PROCESSED_RECIP_ID

OUTPAT_RECIP_FIRST_NAME

Examine the CMS-1500 or any claim forms. If there is no claim form or history, code as missing.

Claim Form or History										
Element	Comparison								Match	Error Type
Date of Service	OUTPAT_FIRST_DT_SVC								0 = No 1 = Yes	Code only 1, 8, 9, or 0
	m	m	d	d	y	y	y	y		
Missing = 99999999										
Comment (Required if Error Type = Other)										
Primary Diagnosis	OUTPAT_DX_1								0 = No 1 = Yes	Code only 1, 3, 8, 9, or 0
Decimal is implied. Start at left. If only 3 or 4 digits, leave the right spaces blank.										
Missing = 99999										
Comment (Required if Error Type = Other)										
Primary Diagnosis Description	DX_DESCRIPTION								0 = No 1 = Yes	Code only 8, 9, or 0
Comment (Required if Error Type = Other)										
Procedure Code	OUTPAT_DTL_PROC								0 = No 1 = Yes	Code only 1,3,8, or 9
Comment (Required if Error Type = Other)										
Procedure Description	OUPT_DESCR								0 = No 1 = Yes	Code only 3,8, or 9
Comment (Required if Error Type = Other)										

End Time

h	h	m	m
		:	

Medical record protocols

Abstraction tool

Need to preprint selected encounters to be validated, with primary diagnosis and CPT code

Need spaces for additional encounters

Record referrals, prescriptions, and lab procedures

Experienced clinical coders

Requests

Docs need to include billing information, i.e., primary diagnosis code, CPT code, etc.

June 1, 2006 to September 1, 2006

All documentation of encounter claim data, to include progress notes, lab sheets, referrals, prescriptions, flow sheets, forms, and dates of services.

Provider identification number, place of service, etc..

Photocopy of claim form

Printout of electronic medical record
notes

PERFORMANCE MEASURES MEDICAL RECORD ABSTRACTION TOOL - AWC

Adolescent Well-Care Visits (AWC) Abstraction Tool																											
Patient Name	<table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td> </tr> </table> <p style="text-align: center; margin-top: 5px;">Last</p>																										
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	<table style="width: 100%; text-align: center; margin-bottom: 5px;"> <tr> <td style="width: 25px;">m</td><td style="width: 25px;">m</td><td style="width: 25px;">d</td><td style="width: 25px;">d</td><td style="width: 25px;">y</td><td style="width: 25px;">y</td><td style="width: 25px;">y</td><td style="width: 25px;">y</td> </tr> </table> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td> </tr> </table>											m	m	d	d	y	y	y	y								
m	m	d	d	y	y	y	y																				
Date of Birth <small>Missing = 11119999</small>																											
Provider Name	<table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td> </tr> </table> <p style="text-align: center; margin-top: 5px;">Last</p>																										
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Name of MCHP (Check only one)	<div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> Mercy CarePlus (1) </div> <div style="width: 50%;"> <input type="checkbox"/> Family Health Partners (5) </div> <div style="width: 50%;"> <input type="checkbox"/> HealthCare USA (2) </div> <div style="width: 50%;"> <input type="checkbox"/> Blue-Advantage Plus (6) </div> <div style="width: 50%;"> <input type="checkbox"/> Harmony Health Plan (3) </div> <div style="width: 50%;"> <input type="checkbox"/> Missouri Care (4) </div> </div>																										
Abstractor Initials	<table border="1" style="width: 100%; border-collapse: collapse; height: 30px;"></table>																										
Date of abstraction	<table style="width: 100%; text-align: center; margin-bottom: 5px;"> <tr> <td style="width: 25px;">m</td><td style="width: 25px;">m</td><td style="width: 25px;">d</td><td style="width: 25px;">d</td><td style="width: 25px;">y</td><td style="width: 25px;">y</td> </tr> </table> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td><td style="width: 25px; height: 25px;"></td> </tr> </table>											m	m	d	d	y	y										
m	m	d	d	y	y																						
Data entry operator initials	<table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td style="width: 50px; height: 40px;"></td><td style="width: 50px; height: 40px;"></td> </tr> </table>																										

Start Time	<table style="margin: auto;"> <tr> <td style="text-align: center;">h</td> <td style="text-align: center;">h</td> <td style="text-align: center;">m</td> <td style="text-align: center;">m</td> </tr> <tr> <td style="border: 1px solid black; width: 40px; height: 30px;"></td> <td style="border: 1px solid black; width: 40px; height: 30px;"></td> <td style="border: 1px solid black; width: 40px; height: 30px;"></td> <td style="border: 1px solid black; width: 40px; height: 30px;"></td> </tr> </table>	h	h	m	m												
h	h	m	m														
Search the medical record for a well care visit during the calendar year																	
Source of Documentation:	<input type="checkbox"/> Medical Record (1) <input type="checkbox"/> Claim Form (2) <input type="checkbox"/> Both (3) <input type="checkbox"/> None (0)																
Documented Components of Well Care Visit: (Check all that apply)	Health and Developmental History <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) Physical Exam <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) Anticipatory Guidance <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)																
Date of Well Care Visit Unless ALL components above are checked, code Missing = 11119999	<table style="margin: auto;"> <tr> <td style="text-align: center;">m</td> <td style="text-align: center;">m</td> <td style="text-align: center;">d</td> <td style="text-align: center;">d</td> <td style="text-align: center;">y</td> <td style="text-align: center;">y</td> <td style="text-align: center;">y</td> <td style="text-align: center;">y</td> </tr> <tr> <td style="border: 1px solid black; width: 40px; height: 30px;"></td> <td style="border: 1px solid black; width: 40px; height: 30px;"></td> <td style="border: 1px solid black; width: 40px; height: 30px;"></td> <td style="border: 1px solid black; width: 40px; height: 30px;"></td> <td style="border: 1px solid black; width: 40px; height: 30px;"></td> <td style="border: 1px solid black; width: 40px; height: 30px;"></td> <td style="border: 1px solid black; width: 40px; height: 30px;"></td> <td style="border: 1px solid black; width: 40px; height: 30px;"></td> </tr> </table>	m	m	d	d	y	y	y	y								
m	m	d	d	y	y	y	y										
Procedure Code Missing = 99999 Insufficient Information = 22222 Don't Know = 88888 See list to the right of Procedure Codes. Does procedure code match one of these?	<table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <table style="border: 1px solid black; width: 100%; height: 30px; margin-bottom: 10px;"></table> <table style="border: 1px solid black; width: 100%; height: 30px;"></table> </td> <td style="width: 50%; vertical-align: top;"> Acceptable Procedure Codes: <div style="border: 1px solid black; padding: 5px; text-align: center;"> 99383, 99384, 99385, 99393, 99394, 99395 </div> </td> </tr> </table>	<table style="border: 1px solid black; width: 100%; height: 30px; margin-bottom: 10px;"></table> <table style="border: 1px solid black; width: 100%; height: 30px;"></table>	Acceptable Procedure Codes: <div style="border: 1px solid black; padding: 5px; text-align: center;"> 99383, 99384, 99385, 99393, 99394, 99395 </div>														
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Procedure Code Match	<table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) </td> <td style="width: 50%; vertical-align: top;"> Acceptable Diagnosis Codes: <div style="border: 1px solid black; padding: 5px;"> <table style="width: 100%;"> <tr> <td>V20.2</td> <td>V70.5</td> <td>V70.9</td> </tr> <tr> <td>V70.0</td> <td>V70.6</td> <td></td> </tr> <tr> <td>V70.3</td> <td>V70.8</td> <td></td> </tr> </table> </div> </td> </tr> </table>	<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)	Acceptable Diagnosis Codes: <div style="border: 1px solid black; padding: 5px;"> <table style="width: 100%;"> <tr> <td>V20.2</td> <td>V70.5</td> <td>V70.9</td> </tr> <tr> <td>V70.0</td> <td>V70.6</td> <td></td> </tr> <tr> <td>V70.3</td> <td>V70.8</td> <td></td> </tr> </table> </div>	V20.2	V70.5	V70.9	V70.0	V70.6		V70.3	V70.8						
<input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0)	Acceptable Diagnosis Codes: <div style="border: 1px solid black; padding: 5px;"> <table style="width: 100%;"> <tr> <td>V20.2</td> <td>V70.5</td> <td>V70.9</td> </tr> <tr> <td>V70.0</td> <td>V70.6</td> <td></td> </tr> <tr> <td>V70.3</td> <td>V70.8</td> <td></td> </tr> </table> </div>	V20.2	V70.5	V70.9	V70.0	V70.6		V70.3	V70.8								
V20.2	V70.5	V70.9															
V70.0	V70.6																
V70.3	V70.8																

<p>Diagnosis Code</p> <p>Decimal is implied. Start at left. If only 3 or 4 digits, leave the right spaces blank.</p> <p>Missing = 99999</p> <p>Insufficient Information = 22222</p> <p>Don't Know = 88888</p> <p>Diagnosis Code Match</p> <div style="display: flex; align-items: center; margin-top: 10px;"> <input type="checkbox"/> Yes (1) <input type="checkbox"/> No (0) </div> <div style="display: flex; align-items: center; margin-top: 10px;"> <div style="text-align: center; margin-right: 5px;">h</div> <div style="border: 1px solid black; width: 40px; height: 20px; margin-right: 5px;"></div> <div style="text-align: center; margin-right: 5px;">h</div> <div style="border: 1px solid black; width: 40px; height: 20px; margin-right: 5px;"></div> <div style="text-align: center; margin-right: 5px;">m</div> <div style="border: 1px solid black; width: 40px; height: 20px; margin-right: 5px;"></div> <div style="text-align: center; margin-right: 5px;">m</div> <div style="border: 1px solid black; width: 40px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 40px; height: 20px;"></div> </div> <p>End Time</p>	<p>Notes:</p> <div style="border: 1px solid black; height: 250px; margin-top: 10px;"></div>
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Were three Hep Bs completed by the members' 13th birthday?

Was one dose of the two-dose regimen and 2 other doses of Hep B completed by the members' 13th birthday?

Appendix 11 – Agenda for Site Visits



SITE VISIT AGENDA

July 23, 2008 -- Morning

TIME	ACTIVITY	ATTENDEES	LOCATION
8:30 - 9:00	Introduction – Opening	BHC, Inc. – Amy McCurry Schwartz Mona Prater Myrna Bruning Stephani Worts Healthplan Attendees	
9:00 – 10:30	Compliance Review —Interviews with Member Services Staff	BHC, Inc. – Mona Prater Myrna Bruning Amy McCurry Schwartz Healthplan Attendees – Member Services Staff	
10:30 – 10:45	Break – Order Lunch		
10:45 – 12:45	Compliance Review – Care Management Interviews	BHC, Inc. – Mona Prater Myrna Bruning Healthplan Care/Case Managers	

9:00 – 11:30	<p>Validation of Performance Measures – Interviews</p> <p>Information Systems Capabilities Assessment – Interviews</p> <p>Document Review – May require access to computers and individuals who can answer questions and access data files that produce the HEDIS measures.</p>	<p>BHC, Inc. – Amy McCurry Schwartz Stephani Worts</p> <p>Healthplan Attendees</p>	
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Afternoon

Time	Activity	Attendees	location
12:45 – 1:30	Working Lunch On Site Reviewer Meeting	BHC, Inc. Staff	
1:30 – 2:30	Compliance Review – Interviews with Administrative Staff	<p>BHC, Inc. – Amy McCurry Schwartz Mona Prater Myrna Bruning</p> <p>Healthplan Attendees</p>	
2:30 – 2:45	Break		
2:45 – 3:45	Validation of Performance Improvement Projects	<p>BHC, Inc. – Amy McCurry Schwartz Mona Prater Myrna Bruning</p> <p>Healthplan Attendees</p>	
3:45 – 4:00	Exit Conference Preparation	BHC, Inc. Staff	
4:00 – 4:30	Exit Conference	<p>BHC, Inc. -- Amy McCurry Schwartz Mona Prater Myrna Bruning Stephani Worts</p> <p>Healthplan Attendees</p>	

Appendix 12 – Compliance Review Scoring Form

2007 BHC MO HealthNet Managed Care Health Plan Compliance Review Scoring Form

This document is used to score the number of items met for each regulation by the health plan.

1. Review all available documents prior to the site visit.
2. Follow-up on incomplete items during the site visit.
3. Use this form and the findings of Interviews and all completed protocols to complete the Documentation and Reporting Tool and rate the extent to which each regulation is met, partially met, or not met.

Scores from this form will be used to compare document compliance across all health plans.

0 = Not Met: Compliance with federal regulations could not be validated.

1 = Partially Met: Health Plan practice or documentation indicating compliance was observed, but total compliance could not be validated.

2 = Met: Documentation is complete, and on-site review produced evidence that health plan practice met the standard of compliance with federal regulations.

	<i>Contract Compliance Tool</i>	<i>Federal Regulation</i>	<i>Description</i>	<i>Comments</i>	<i>2007 Site Visit and Findings</i>	<i>2006 Rating 0 = Not Met 1 = Partially Met 2 = Met</i>	<i>2007 Rating 0 = Not Met 1 = Partially Met 2 = Met</i>
Subpart C: Enrollee Rights and Protections							
1	2.6.1(a)1-25, 2.2.6(a), 2.6.2(j)	438.100(a)	Enrollee Rights: General Rule				
2	2.6.1(a)1, 2.9, 2.6.2(j), 2.6.2(n)	438.10(b)	Enrollee Rights: Basic Rule				
3	2.15.2(e), 2.8.2	438.10(c)(3)	Alternative Language: Prevalent Languages				
4	2.8.2, 2.8.3, 2.6.2(n)(2)	438.10(c)(4,5)	Language and format: Interpreter Services				

5	2.6.1(a)1, 2.6.2(n)1	438.10(d)(1)(i)	Information Requirements: Alternative Formats				
6	2.6.1(a)1, 2.6.2(n)2 - dot point 35, 2.6.2(q), 2.8.2, 2.8.3	438.10(d)(1)(ii)and (2)	Information Requirements: Easily Understood				
7	2.3.5, 2.6.1(a)2/3, 2.6.2(k)1, 2.6.2(n), 2.6.2(n)(2), 2.6.2(q)	438.10(f)	Enrollee Rights: Information, Free Choice				
8	2.6.2(n)(2)	438.10 (g)	Information to Enrollees: Physician Incentive Plans				
9	2.4, 2.4.5, 2.4.5(a)2-4, 2.20.1(all), 3.5.3(f)	438.10(i)	Liability for Payment and Cost Sharing				
10	2.2.6(a), 2.2.6(b), 2.6.1(a)(3), 2.6.2(j), 2.9.1	438.100(b)(2)(iii)	Specific Enrollee Rights: Provider- Enrollee Communications				
11	2.6.2(j), 2.30.1, 2.30.2, 2.30.3	438.100(b)(2)(iv,v)	Right to Services, including right of refusal. Advance Directives				
12	2.6.2(j), 2.4.8, 2.13, 2.14	438.100(b)(3)	Right to Services				
13	2.2.6, 2.14.3, 2.14.8, 2.14.9	438.100(d)	Compliance with Other State Requirements				

		Total Enrollee Rights and Protections					
Subpart D: Quality Assessment and Performance Improvement							
Subpart D: Quality Assessment and Performance Improvement: Access Standards							
14	2.3.1, 2.6.2(j), 2.14.3, 2.7.1(g), 3.5.3	438.206(b)(1)(i-v)	Availability of Services: Provider Network				
15	2.7.1(e), 2.7.1(f), 2.14.8	438.206(b)(2)	Access to Well Woman Care: Direct Access				
16	2.13	438.206(b)(3)	Second Opinions				
17	2.3.2, 2.3.18, 2.7.1(bb), 2.12.3, 2.12.4, 2.14.5	438.206(b)(4)	Out of Network Services: Adequate and Timely Coverage				
18	2.4, 2.20.1(d)	438.206(b)(5)	Out of Network Providers: Cost Sharing				
19	2.3.14(a)2, 2.14.1, 2.14.4(a- f), 2.17.1, 3.5.3	438.206(c)(1)(i-vi)	Timely Access				
20	2.2.6(a)1-3, 2.17.1	438.206(c)(2)	Cultural Considerations				
21	2.14.11, 2.3.5(e)	438.208(b)	Primary Care and Coordination of Healthcare Services				
22	2.6.2(m), 2.14.11, 2.5.3(e)	438.208(c)(1)	Care Coordination: Identification				

Report of Findings – 2007

Compliance Review Scoring Form

23	2.12.10, 2.14.2(c), 2.14.11, 2.17.5, Attachment 3 - Children with Special Healthcare Needs	438.208(c)(2)	Care Coordination: Assessment				
24	2.7.1, 2.12, 2.14.11	438.208(c)(3)	Care Coordination: Treatment Plans				
25	2.3.8, 2.3.7, 2.6.1(k)(3), 2.14.6, 2.14.7	438.208(c)(4)	Access to Specialists				
26	2.2.1(i), 2.3.7, 2.7.4, 2.9.2, 2.10.2, 2.14.1, 2.14.2(a-h), 2.14.2(d)1-2	438.210(b)	Authorization of Services				
27	2.15.4, 2.14.2(d)6	438.210(c)	Notice of Adverse Action				
28	2.6.2(k)(3), 2.14.2(d)6, 2.15.4(a-c), 2.16.3(e)	438.210(d)	Timeframe for Decisions				
29	2.17.5(b)	438.210(e)	Compensation for Utilization Management Decisions				
30	2.4.8, 2.7.1, 2.7.1(y), 2.7.3(v), 2.14.2	438.114	Emergency and Pos-stabilization pgs 24/25 Rev. Checklist				

Subpart D: Quality Assessment and Performance Improvement: Structure and Operation Standards							
31	2.17.2(n), 2.17.5(c), 2.30.2	438.214(a,b)	General Rules for Credentialing and Recredentialing				
32	2.2.6(b)(c)	438.214(c) and 438.12	Nondiscrimination and Provider Discrimination Prohibited				
33	2.31.5	438.214(d)	Excluded Providers				
34	2.3.9, 2.3.17	438.214(e)	Other State Requirements: Provider Selection				
35	2.6.2(n)(2), 2.6.2(s)(all), 2.6.2(u)	438.226 and 438.56(b)(1-3)	Disenrollment: Requirements and Limitations				
36	2.5.1, 2.5.2, 2.5.6, 2.6.1(g), 2.6.2®	438.56(c)	Disenrollment Requested by Enrollee				
37	2.6.2(r,s-1,t)	438.56(d)	Procedures for Disenrollment -- Pgs 29/30 Rev. Checklist				
38	2.6.2(u)	438.56(e)	Timeframe for Disenrollment Determinations				
39	2.15, 2.15.3(a,b)	438.228	Grievance Systems				
40	2.6.1(a)(18), 2.16.2(c), 2.31.2(a)8, 2.31.3, 3.5.1, 3.5.2, 3.5.3	438.230(a,b)	Subcontractual Relationships and Delegation				

Subpart D: Quality Assessment and Performance Improvement: Measurement and Improvement							
41	2.17.2(d)	438.236(b)(1-4)	Adoption of Practice Guidelines	There is very little in the contract compliance tool regarding practice guidelines.			
42	2.17.2(d)	438.236(c)	Dissemination of Practice Guidelines				
43	2.17.2(d,f)	438.236(d)	Application of Practice Guidelines -- Pgs 32/33 of Rev. Checklist				
44	2.17.1, 2.17.5	438.240(a)(1)	Quality Assessment and Improvement Program				
45	2.17.5(d)	438.240(b)(1) and 438.240(d)	Basic Elements of MCO QI and PIPs				
46	2.17, 2.17.3, Attachment 6	438.240(b)(2)(c) and 438.204(c)	Performance Measurement				
47	2.17.5(b)	438.240(b)(3)	Basic elements of MCO QI and PIPs: Monitoring Utilization				
48	2.17.5	438.240(b)(4)	Basic elements of MCO QI and PIPs				
49	Attachment 6 - State Quality Strategy	438.240(e)	Program Review by State				
50	2.25	438.242(a)	Health Information Systems				

51	2.25(all) - 2.25.1, 2.25.2(a,b), 2.25.3, 2.25.4	438.242(b)(1,2)	Basic Elements of HIS				
52	2.26.1, 2.29.1	438.242(b)(3)	Basic Elements of HIS				
		Total Quality Improvement and Assessment					
Subpart F: Grievance Systems							
53	2.15	438.402(a)	Grievance and Appeals: General Requirements				
54	2.15.2, 2.15.5(a), 2.15.6(a)	438.402(b)(1)	Grievance and Appeals: Filing Authority				
55	2.15.6(a)	438.402(b)(2)	Grievance and Appeals: Timing				
56	2.15.2(a), 2.15.5(a), 2.15.6(a,b)	438.402(b)(3)	Grievance and Appeals: Procedures				
57	2.15.2(e), 2.15.4(a), 2.6.2(q)	438.404(a)	Notice of Action: Language and Format				
58	2.15.4(b)	438.404(b)	Notice of Action: Content				
59	2.15.4(c)	438.404(c)	Notice of Action: Timing				
60	2.15.5(b,c,d), 2.15.6(h,i,j)	438.406(a)	Handling of Grievances and Appeals: General Requirements				

61	2.15.6(g) 2.15.6(h) 2.15.6(i) 2.15.6(j)	438.406(b)	Handling of Grievances and Appeals: Special Requirements				
62	2.15.5(e), 2.15.6(k)	438.408(a)	Resolution and notification: Grievances and Appeals - Basic rule				
63	2.15.5(e,f), 2.15.6(k-l)	438.408(b,c)	Resolution and notification: Grievances and Appeals - Timeframes and extensions				
64	2.15.5(e), 2.15.6(k,m)	438.408(d)(e)	Resolution and notification: Grievances and Appeals - Format and content				
65	2.15.2(i), 2.15.6(m)	438.408(f)	Resolution and notification: Grievances and Appeals - Requirements for State fair hearing				
66	2.15.6(n,o)	438.410	Expedited resolution of appeals				
67	2.15.2(c), 3.5.3(c)	438.414	Information about the grievance systems of providers and subcontractors				
68	2.15.3	438.416	Recordkeeping and reporting				

			Continuation of Benefits while the MCO/PIHP Appeal and the State Fair Hearing are Pending				
69	2.15.6(p)	4388.420					
70	2.15(q,r)	438.424	Effectuation of reversed appeals				
		Total All Items					
This protocol was developed using the CMS MCO Compliance protocol worksheet and cross-matching the State of Missouri Eastern/Central Region contract and the State supplied Compliance Tool for 2004.							



Appendix 13 – Compliance Interview Tools

CASE MANAGEMENT STAFF



Behavioral Health Concepts, Inc.

Victoria Park, 2716 Forum Blvd., Suite 4, Columbia, MO 65203

*(573) 446-0405
(573) 446-1816 (fax)
(866) 463-6242 (toll-free)
www.bhcinfo.com*

Care/Case Manager Interview Protocol 2007 EQRO

Member Rights and Protections

1. How do you receive referrals for case/care management services?
2. When you receive a new referral what do you do?
3. Describe what you do when you are case managing a member? Are contacts and service information recorded in an information system? Who participates in the decision-making process?
4. How does the healthplan ensure that members participate in care and treatment decisions?
5. Are members informed of their right to accept or refuse treatment and to execute an advance directive? Are you aware of the healthplan's policies on implementation of this right?
6. Describe any training or information you have received about the Federal/State laws regarding member rights that must be observed in day-to-day operations? How did this occur?

Quality Assessment and Performance Improvement Access Standards

1. How are members with special health care needs identified and tracked within your system?



Performance Management Solutions Group
A division of Behavioral Health Concepts, Inc.

2. What mechanisms does the healthplan employ to assess member's service needs? How are assessment activities conducted?
3. Describe a time when you assisted a member in obtaining special services, such as home health care. If this has never occurred, has this type of service been requested? If it is never authorized, what is the healthplan policy about approving special services? What circumstances would have to exist for these services to be authorized?
4. How do you assist in developing a written treatment plans when a member has an ongoing special condition that requires a course of treatment or regular care monitoring? How is it decided which members receive a written treatment plan?
5. How are written treatment plans developed? How do you ensure that the care plan addresses the needs identified in the assessment?
6. Describe the treatment planning process, and the process used to determine the appropriate use of specialists?
7. How many treatment plans are developed annually? Were any requests for treatment planning denied? Why?
8. Describe the processes used to coordinate services for members? Are they different for different types of member needs?
9. Who is responsible for coordinating the care of members with special health care needs?
10. How do you coordinate medical services and mental health/substance abuse services? Do you exchange information between providers?
11. Are you aware of the proportion of members having an ongoing source of primary care?
12. How many members have someone designated as preliminarily responsible for coordination their health care services? (percentage?) How many of these are members with special health care needs?

Measurement and Improvement Standards

1. Have you or other case management staff ever received a request from a member for practice guidelines? How was this handled?

Grievance Systems

1. Tell us how you handle a situation when an authorization decision is adverse to a member?
2. If a member indicates they wish to file a grievance, what do you do?
3. If a member remains dissatisfied and indicates that they want to file an appeal what do you do? Are members required to exhaust the internal appeal process before seeking and receiving a State fair hearing?
4. Who assists members in negotiating the healthplan's grievance and appeals system, including completing forms or taking other steps to resolve an appeal or grievance? Do you ever assist a member? If they indicate a need for assistance, who helps them?
5. What happens if a member makes an oral request to appeal an action?
6. How often are grievances and appeals analyzed for trends? Do you receive reports of this type of analysis? What action is taken?
7. Are you ever involved in the analysis of grievances and appeals and how this reflects on the healthplans service delivery system? Does the healthplan have a Quality Assessment and Performance Improvement Program?
8. Can members continue to receive benefits during the grievance/appeal process? If they do and the grievance/appeal is upheld what happens?

MEMBER SERVICES STAFF



Behavioral Health Concepts, Inc.

Victoria Park, 2716 Forum Blvd., Suite 4, Columbia, MO 65203

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(573) 446-1816 (fax)
(866) 463-6242 (toll-free)
www.bhcinfo.com*

Member Services Staff Interview Protocol EQR 2007

Enrollee Rights and Responsibilities

Goal: To confirm that the health plan is effectively implementing policies and procedures to communicate with members about the rights, their rights to information, and to supplement information obtained in document review.

Member Services Staff

1. Give us an example of the type of information provided to an individual if they call asking a question about the healthplan. What information is routinely provided to members? How is this information disseminated to new members? Is there a different script for existing members? What format is used?
2. Tell us about a situation where you realized that you needed to communicate with a caller in a different language or in an alternative format. How is the need for an alternative language or format determined? What procedures exist for handling communications with non-English speaking members?
3. Describe how you inform members of available providers? What would you do if a member asked for a provider who speaks another language, or has specific cultural characteristics?
4. How do you inform members of termination of a contracted provider? What has occurred when a PCP is terminated? Are you aware of this type of situation within the past year?
5. Describe what you would do if a member called and complained that they were treated badly and their privacy was compromised by discussion of their situation in a public setting at a provider's office.

6. How does the healthplan monitor member rights to service availability, coordination and continuity of care, coverage and authorization of service, and to obtain a second opinion? What are the most recent results of any monitoring that has occurred?
7. What would you if a member called asking to obtain access to their medical records, or other information obtained by the healthplan or their providers? (Are members informed of their right to request and receive a copy of their medical records, and their right to request that these records be amended or corrected?)
8. I'm a members and I call with a concern. Describe what happens or how this might be handled.
9. Describe any training or information you have received about the Federal/State laws regarding member rights that must be observed in day-to-day operations? How did this occur?
10. Have you received any complaints from members involving a perceived violation of the rights? How was this resolved?
11. Is any information been collected to determine that care and services are provided in a timely manner? If the MCO learns that this is not occurring, what action occurs?

Quality Assessment and Performance Improvement Access Standards

13. What occurs if a member calls and states that they can not receive services when they are needed (after normal business hours or on Saturdays)?
14. Describe a situation when a member complains that they can not get a service they believe they need. (What types of service require prior authorization? What occurs if you determine that a member needs a service requiring a prior authorization?)
15. How frequently does member services staff receive complaints about provider hours, or not being able to get timely services or appointments? If you receive and pass on a complaint about the unavailability of a provider, are you informed about any corrective action taken?
16. Tell us about a time when a member called and appears to have special health care needs? What did you do?

17. How frequently do you receive complaints about difficulty obtaining emergency or post-stabilization services? Describe the procedure for handling member calls regarding need for emergency services.
18. Does the MCO conduct surveys, focus groups, or other activities to receive feedback from members? Are you aware of any findings?

Structure and Operation Standards

19. What do you do if a member requests disenrollment. Is this information or action tracked? Does this occur often?
20. Describe the process for informing members of any decision to deny, limit, or discontinue a request for service. What are the time frames for notification?

Measurement and Improvement Standards

21. Have you or other member service staff ever received a request, from a member, for practice guidelines? How was this handled?

Grievance Systems

22. If a member contacts you and says they want to file a grievance, how do you handle this? Are there materials that contain information about the grievance and appeal process? When do members receive this information?
23. What happens if you determine that an issue presented is a grievance. Describe your actions if you think this is a complaint that does not rise to the level of a member grievance. What type of issues do members call to complain about or file a grievance? (Has the MCO received complaints from members who had difficulty obtaining timely access to the records? How was this resolved?)
24. Are you aware of the MCO's grievance resolution process? How do you understand this process? The appeals process?
25. How is it determined that an enrollee's appeal requires expedited resolution?

26. How is the member informed on a denial of a request for an expedited resolution?
27. How many issues become a State Fair Hearing?
28. Who assists members in using the organization's grievance and appeals system, including completing forms or taking other steps to resolve an appeal or grievance? If a member indicates a need for assistance, who helps them?
29. What happens is a member makes a verbal request to appeal an action?
30. Are you ever involved in the analysis of grievances and appeals and how this reflects on the healthplan's service deliver system? Does the healthplan have a Quality Assessment and Performance Improvement Program? Are you involved? How?
31. Can members continue to receive benefits during the grievance/appeal process? If they do and the grievance/appeal is upheld

Appendix 14 – Site Visit Information Request Letter

June XX, 2008

<Plan Administrator>
<Plan Name>
<Address>

RE: SITE VISIT AGENDA AND DOCUMENT REVIEW

Dear _____:

We are finalizing plans for the on-site reviews of each MCO. The following information is being provided in an effort to make preparations for the on-site review as efficient as possible for you and your staff. The following information or persons will be needed at the time of the on-site review at <Health Plan Name> on July XX, 2008.

Performance Improvement Projects

Time is scheduled in the afternoon to conduct follow-up questions, review databases, and provide verbal feedback to the MCO regarding the planning, implementation, and credibility of findings from the Performance Improvement Projects (PIPs). Any staff responsible for planning, conducting, and interpreting the findings of PIPs should be present during this time. The review will be limited to the projects and findings submitted at the end of 2007. Please be prepared to review databases and any data collection forms not originally submitted.

Performance Measure Validation

As you know, BHC is in the process of validating the following three performance measures:

- HEDIS 2007 Follow-Up After Hospitalization for Mental Illness
- HEDIS 2007 Annual Dental Visit
- HEDIS 2007 Adolescent Well Care

BHC is following the CMS protocol for validating performance measures. The goals for this process are to:

- Evaluate the accuracy of Medicaid performance measure reported by the MCO; and
- Determine the extent to which Medicaid-specific performance measures calculated by the MCO followed specifications established by the Division of Medical Services. These specifications consist of the HEDIS 2007 Technical Specifications.

To complete this process we will review the following documents while on-site:

▪ **Data Integration and Processes Used to Calculate and Report Performance Measures**

1. Documentation of the performance measure generating process
2. Documentation of computer queries, programming logic, or source code (if available) used to create denominators, numerators and interim data files - for each of the three measures
3. Code mapping documentation
4. Documentation of results of statistical tests and any corrections with justification for such changes, if applicable - for each of the three measures
5. Documentation showing confidence intervals of calculations when sampling methodology used – for each of the three measures
6. Description of the software specifications or programming languages instructions used to query each database to identify the denominator, and/or software manual
7. Source code for identifying the eligible population and continuous enrollment calculation – for each of the three measures
8. Description of the software specification or programming languages used to identify the numerator
9. Programming logic and/or source code for arithmetic calculation of each measure to ensure adequate matching and linkage among different types of data

▪ **Sampling Validation**

1. Description of software used to execute sampling sort of population files
2. Source code for how samples for hybrid measures were calculated
3. Policies to maintain files from which the samples are drawn in order to keep population intact in the event that a sample must be re-drawn or replacements made
4. Documentation that the computer source code or logic matches the specifications set forth for each performance measure, including sample size and exclusion methodology
5. Documentation of “frozen” or archived files from which the samples were drawn
6. Documentation assuring that sampling methodology treats all measures independently, and there is no correlation between drawn samples

Performance Measure Interviews

In addition to the documentation reviews, interviews will be conducted with the person(s) responsible for:

- Overseeing the process of identifying eligible members from MCO data sources for the measures to be validated;
- Programming the extraction of required elements from the MCO data sources for the measures to be validated;
- Integrity checks and processes of verifying the accuracy of data elements for the measures to be validated;

- Overseeing the process of medical record abstraction, training, and data collection for the measures to be validated; and
- Contractor oversight and management of any of the above activities.

On-site activities may also include, but are not limited to, the following:

- Demonstration of HEDIS software
- Demonstration of the process for extracting data from MCO databases
- Possible data runs for identifying numerator and denominator cases

Compliance Review

The final activity to prepare for during the on-site visit will be staff interviews with Member Services Staff, Case/Care Management Staff, and Healthplan Administrators. Documentation reviews and interviews with MO HealthNet staff have occurred prior to the on-site visit. This enables BHC to use the time at the MCO as efficiently as possible. Some documentation will be reviewed at the Healthplan Offices prior to the on-site review date. The following information will be needed during this pre-review on-site time:

Compliance Documents

- Member Handbook
- 2007 Marketing Plan and materials
- Grievance logs (members and providers)
-

Compliance Interviews

The attached agenda requests an interview in the morning with the Member Services and Case/Care management staff. A group of four (4) to six (6) representatives from each work group will be appreciated.

We will also interview Healthplan Administrative staff. It will be helpful to include the following:

- Plan Director
- Medical Director
- Quality Assurance Director
- Provider Services/Provider Relations Director
- Member Services Director
- Utilization Management Director
- Case Management Director

Concurrent activities and interviews are scheduled in the morning. If separate conference rooms or meeting space can be arranged, this will make the process much easier to coordinate. Also, the on-site review team will need to order a working lunch on the day of the visit. If lunch facilities are not available, please provide the name and telephone number of a service in your vicinity that can accommodate ordering lunch. Your assistance will be appreciated.

The Healthplan staff involved in any of the referenced interviews or activities, or anyone identified by the Healthplan, is welcome to attend the introduction and/or the exit interview.

Again, your assistance in organizing the documents, individuals to be interviewed, and the day's activities is appreciated. If you have questions, or need additional information, please let me know.

Sincerely,

Mona Prater
Assistant Project Director

Cc: Amy McCurry Schwartz, Esq., Project Director
Susan Eggen, Division of Medical Services

Attachment:
On-Site Review Agenda